Health Home Program
Washington

Health Home Care Coordinators Basic Training

January 2021

Washington State Health Care Authority

> "I diagnosed 'abdominal pain' when the real problem was hunger, I confused social issues with medical problems in other patients, too. I mislabeled the hopelessness of long-term unemployment as depression and the poverty that causes patients to miss pills or appointments as noncompliance. In one older patient, I mistook the inability to read for dementia. My medical training had not prepared me for this ambush of social circumstance. Real-life obstacles had an enormous impact on my patients' lives, but because I had neither the skills nor the resources for treating them, I ignored the social context of disease altogether."
>
> *—Laura Gottlieb, MD*
> *University of California San Francisco*

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Introductions

Your **name**?

What do you **do**?

What **agency** do you work for?

What **Lead Organization/s** will you work with?

Briefly state, your **relevant work experience.**

3

Purpose

Provide the core curriculum for Health Homes in Washington State for Lead Organizations and Care Coordination Organizations (CCOs)

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Learning Objectives and Agenda Overview

- The six Health Home services
- Outreach and engagement strategies
- Care coordination key components and delivery mechanisms
- Administration of Insignia's Patient Activation Measures ® and how to use the level of activation to develop a Health Action Plan

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Learning Objectives and Agenda Overview (cont.)

- Administration of mandatory screens and optional screens
- Documentation of the delivery of Health Home Services in progress notes and Health Action Plans
- Required elements for Care Transitions

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Overview of the Curriculum

Classroom Training Manual with important forms and documents

Location of the manual on the DSHS training Website: https://www.dshs.wa.gov/altsa/stakeholders/washington-health-home-program-core-training

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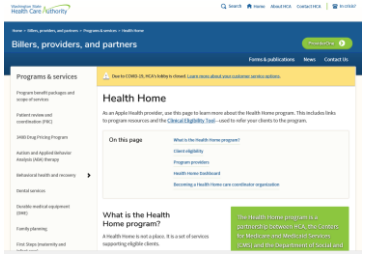
The Health Care Authority (HCA) Website

https://www.hca.wa.gov/billers-providers-partners/programs-and-services/health-homes



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The DSHS Website

https://www.dshs.wa.gov/altsa/washington-health-home-program

Training, resources, newsletter and webinar invitations & presentations are located on the DSHS ALTSA website

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Fundamentals

Health Homes and the Affordable Care Act
Washington's model
Eligibility
The Health Home services
Health Home tiers and billing

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What are Health Home Services?

Clients receiving Health Home services will be assigned a Health Home Care Coordinator who will **partner** with client, their families, doctors and other agencies providing services to **ensure coordination** across these systems of care.

The primary role of the Health Home Care Coordinator is to work with their client to **develop** a Health Action Plan that is **person-centered**.

In addition, the Health Home Care Coordinator will make in-person **visits** and be available by telephone to **empower the client** to take charge of their wellness.

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Let's look at a sample Health Action Plan (HAP)

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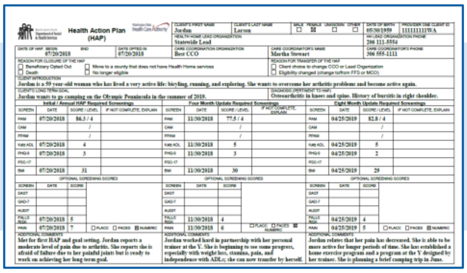
TRAINING

Sample HAP for Jordan Larson



Health Action Plan (HAP)

CLIENT'S FIRST NAME	CLIENT'S LAST NAME	MALE	FEMALE	UNKNOWN	OTHER	DATE OF BIRTH	PROVIDERONE CLIENT ID
Jordan	Larson	☐	☒	☐	☐	05/30/1959	111111111WA

HEALTH HOME LEAD ORGANIZATION	HH LEAD ORGANIZATION PHONE
Statewide Lead	206 111-5554

DATE OF HAP: BEGIN	END	DATE OPTED IN	CARE COORDINATION ORGANIZATION	CARE COORDINATOR'S NAME	CARE COORDINATOR'S PHONE
07/20/2018		07/20/2018	Best CCO	Martha Stewart	306 555-1111

REASON FOR CLOSURE OF THE HAP: ☐ Beneficiary Opted Out ☐ Death ☐ Move to a county that does not have Health Home services ☐ No longer eligible

REASON FOR TRANSFER OF THE HAP: ☐ Client choice to change CCO or Lead Organization ☐ Eligibility changed (change to/from FFS or MCO)

CLIENT INTRODUCTION: Jordan is a 59 year-old woman who has lived a very active life: bicyling, running, and exploring. She wants to overcome her arthritis problems and become active again.

CLIENT'S LONG TERM GOAL: Jordan wants to go camping on the Olympic Peninsula in the summer of 2019.

DIAGNOSIS (PERTINENT TO HAP): Osteoarthritis in knees and spine. History of bursitis in right shoulder.

Initial / Annual HAP Required Screenings

SCREEN	DATE	SCORE / LEVEL	IF NOT COMPLETE, EXPLAIN
PAM	07/20/2018	86.3 / 4	
CAM		/	
PPAM		/	
Katz ADL	07/20/2018	4	
PHQ-9	07/20/2018	3	
PSC-17			
BMI	07/20/2018	31	

Four Month Update Required Screenings

SCREEN	DATE	SCORE / LEVEL	IF NOT COMPLETE, EXPLAIN
PAM	11/30/2018	77.5 / 4	
CAM		/	
PPAM		/	
Katz ADL	11/30/2018	5	
PHQ-9	11/30/2018	3	
PSC-17			
BMI	11/30/2018	30	

Eight Month Update Required Screenings

SCREEN	DATE	SCORE / LEVEL	IF NOT COMPLETE, EXPLAIN
PAM	04/25/2019	82.8 / 4	
CAM		/	
PPAM		/	
Katz ADL	04/25/2019	5	
PHQ-9	04/25/2019	2	
PSC-17			
BMI	04/25/2019	29	

Optional Screening Scores

SCREEN	DATE	SCORE	SCREEN	DATE	SCORE	SCREEN	DATE	SCORE
DAST			DAST			DAST		
GAD-7			GAD-7			GAD-7		
AUDIT			AUDIT			AUDIT		
FALLS RISK	07/20/2018	5	FALLS RISK	11/30/2018	4	FALLS RISK	04/25/2019	4
PAIN	07/20/2018	7	PAIN	11/30/2018	6	PAIN	04/25/2019	5

☐ FLACC ☐ FACES ☒ NUMERIC

ADDITIONAL COMMENTS: Met for first HAP and goal setting. Jordan reports a moderate level of pain due to arthritis. She reports she is afraid of failure due to her painful joints but is ready to work on achieving her long term goal.

ADDITIONAL COMMENTS: Jordan worked hard in partnership with her personal trainer at the Y. She is beginning to see some progress, especially with weight loss, stamina, pain, and independence with ADLs; she can now transfer by herself.

ADDITIONAL COMMENTS: Jordan relates that her pain has decreased. She is able to be more active for longer periods of time. She has established a home exercise program and a program at the Y designed by her trainer. She is planning a brief camping trip in June.

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The Patient Protection and Affordable Care Act

Health Homes are described in:

Section 2703 of the Patient Protection and Affordable Care Act. State option to provide health homes for clients with chronic conditions.

https://www.medicaid.gov/medicaid/long-term-services-supports/health-homes/index.html

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Washington Opts In

The primary goals of the Health Home Program include:

- Improve the quality and coordination of care across systems of care
- Reduce expenditures
- Increase confidence and self management of health goals
- Provide a single point of contact to bridge systems of care

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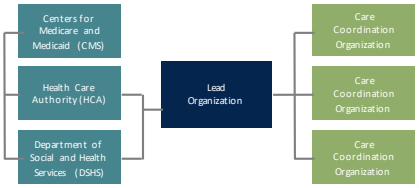
Washington State Model of Health Home



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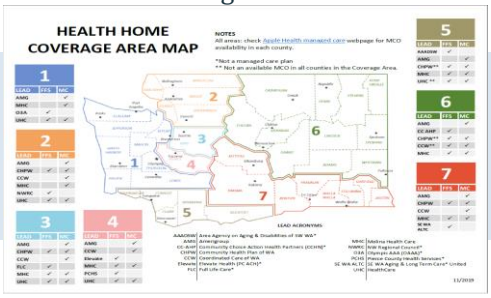
Health Home Coverage Areas



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Who May Become a Health Home Care Coordinator?

Care Coordinators may be employed by:

- Lead Entity or
- Care Coordination Organization that has contracted with a Lead

Required education or licensure:

- Current license as registered nurses, advanced registered nurse practitioners, practical nurses, psychiatric nurses, psychiatrists, physician assistants, clinical psychologists, mental health counselors, agency affiliated counselors, marriage and family therapists or certified chemical dependency professionals; or
- Master's or Bachelor's in social work, psychology, social services, human services and behavioral sciences; or
- Certified Medical Assistants with an Associate Degree or Indian Health Service (IHS) Certified Community Health Representatives (CHR)

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Who May Be Covered By Health Homes?

1. **Dual Eligible**
   - Eligible for Medicare and Medicaid
     - Uses Fee-For-Service (FFS) traditional Medicare/Medicaid providers
2. **Apple Health**
   - Managed Care Organizations (MCO) plans
3. **Fee-for-Service:** traditional Medicaid coverage for those not dually eligible

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Eligibility for Health Home Services

- Must be on active Medicaid, includes dually eligible (Medicaid and Medicare)
- Must have one chronic condition
- At risk for a second chronic condition
  - PRISM score of 1.5 or higher (Indicates risk for a second chronic condition)

Note: includes all ages

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The Health Home Services

Health Home services are designed to:

- ✓ See the client in their home or location of their choice
- ✓ Conduct screenings to identify health risks and referral needs
- ✓ Set person-centered goals that will improve client's health and service access
- ✓ Improve management of health conditions through health action planning, education, and coaching

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The Health Home Services (cont.)

- ✓ Support changes to improve client's ability to function in their home and community and increase self-management of their chronic disease/s
- ✓ Slow the progression of disease and disability
- ✓ Access the right care, at the right time, the right place, and the right provider

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The Health Home Services (cont.)

- ✓ Successfully transition from hospital to other care settings and get necessary follow-up care
- ✓ Reduce avoidable health care costs
- ✓ Make health care decisions during evenings or weekends when the Health Home Care Coordinator is not available

Note: Health Home services do not duplicate other services

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Let's Pause to Check for Understanding

Do you have any experience with the program that you wish to share?

Do you have any questions?

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The Six Health Home Services

1. Comprehensive care management
2. Care coordination
3. Health promotion
4. Comprehensive transitional care
5. Individual and family support
6. Referral to community and social support services

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1 Comprehensive Care Management

1. Provides in-person periodic follow-up using face-to-face visits and telephone calls
2. Includes state approved required and optional screenings and assessments

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1 Comprehensive Care Management (cont.)

3. Assesses the client's readiness for self-management and promotes self-management skills so the client is better able to engage with health and service providers
4. Initiates discussion about advance care planning and assists the client and family (with the client's consent) to access assistance if they wish to pursue advance care planning or an advanced directive

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1 Comprehensive Care Management (cont.)

5. Monthly (or more often as needed) contacts:
   - Provides continuity of care
   - Supports the achievement of self-directed health goals
   - Improves functional or health status or prevent or slow declines in functioning

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2 Care Coordination

1. Provides cross-system care coordination to assist the client to access and navigate needed services
2. Uses the Health Action Plan (HAP) as the person-centered care management plan

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2 Care Coordination (cont.)

3. Fosters communication between the providers of care including:
   - Primary Care Physicians (PCPs)
   - Medical and behavioral health specialists
   - Entities authorizing behavioral health and Long Term Services and Supports (LTSS)

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2 Care Coordination (cont.)

4. Bridges all of the client's systems of care, including non-clinical support such as food, housing, legal services, transportation, etc.

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2 Care Coordination (cont.)

5. Coordinates and may supervise the work of allied, lay, or administrative staff
6. Provides informed interventions that recognize and are tailored to the medical, behavioral, social, economic, cultural, and environmental factors impacting a client's health and health care choices

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2 Care Coordination (cont.)

7. Promotes:
   - Optimal health outcomes through health action planning
   - Outreach and engagement activities that support the client's participation in their care
8. Uses peer supports, support groups, and self-care programs to increase the client's knowledge about their health care conditions and improve adherence to prescribed treatment

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2 Care Coordination (cont.)

9. Provides opportunities for mentoring and modeling communication with health care and other providers by:
   - Modeling or monitoring phone conversations with health care staff and others
   - Rehearsing a visit with a provider to prepare the client for their appointment
   - Participating in joint office visits and appointments

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3 Health Promotion

1. Uses self-management, recovery, and resiliency principles including supports identified by the client
2. Considers the client's activation level to determine the coaching, teaching, and support plan for the client

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3 Health Promotion (cont.)

3. Provides wellness and prevention education to include routine and preventative care (e.g. immunizations)
4. Links the client with resources to promote a healthier lifestyle

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4 Comprehensive Transitional Care

1. Prevents avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing, substance use disorder treatment facility, or residential habilitation setting)
2. Ensures proper and timely follow-up care

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5 Individual and Family Support

1. Recognizes the unique role the client may give family, identified decision makers and caregivers in assisting the client to access and navigate the health care and social service delivery system
2. Supports health action planning

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5 Individual and Family Support (cont.)

3. Identifies the role that families, informal supports, and paid caregivers provide to:
   - Educate and support self-management, self-help, and recovery
   - Achieve self-management and optimal levels of physical and cognitive function

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5 Individual and Family Support (cont.)

4. Educates and supports family informal supports and caregivers
   - Increases their knowledge of chronic conditions
   - Promotes the client's engagement and self-management
   - Helps the client adhere to their prescribed medications and treatments

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5 Individual and Family Support (cont.)

5. Includes:
   - Discussions about advance care planning with clients and their families
   - Communication and information sharing with clients and their families and other caregivers
   - Consideration of language, activation level, literacy, numeracy, and cultural preferences

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6 Referral to Community and Social Support Services

1. Provides assistance to obtain and maintain eligibility for health care services, disability benefits, housing, LTSS, and legal services
2. Completes referrals to community and social support services to support the client in achieving health action goals including:
   - LTSS
   - Mental health and substance use disorder providers
   - Other community and social services support providers as needed

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6 Referral to Community and Social Support Services (cont.)

3. Provides support by:
   - Identifying community based resources
   - Actively managing referrals
   - Advocating and assisting on behalf of the client to access care and community and social supports

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Multidisciplinary Care Teams and Allied Staff

- As a Care Coordinator you may coordinate and facilitate multidisciplinary care teams:
  - Establishing a team to provide cross systems care coordination on behalf of the client
  - Establishing or working with an existing multidisciplinary care team to discuss discharge planning with hospitals, nursing facilities, and other institutions
- As a Care Coordinator you may work with allied staff:
  - Care Coordinators may enlist the help of allied staff including:
    - Community Health Workers, mental health peer support specialists, outreach specialists, Community Connectors, patient navigators, wellness coaches, and other lay staff

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TRAINING

Health Home Tiers

Tier **One**	Tier **Two**	Tier **Three**
Initial engagement and action planning	Intensive level of care coordination	Low level of care coordination

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TRAINING

Tier One Services

Tier One | Tier Two | Tier Three

Requires a face-to-face visit to:

- ✓ Introduce Health Home services
- ✓ Assess the client's health and other needs
- ✓ Confirm the client's agreement to participate
- ✓ Obtain signatures for participation authorization and information sharing consent
- ✓ Complete required and optional screenings

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Tier One Services (cont.)

Tier One | Tier Two | Tier Three

- ✓ Develop the first Health Action Plan (HAP)
- ✓ Document activities
- ✓ Complete the HAP within 90 days that the client was assigned to your agency
- ✓ Bill **one time** only

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Tier Two Services

Tier One | Tier Two | Tier Three

- ✓ Intensive level Health Home care coordination
- ✓ Requires at least one face-to-face visit each month
- ✓ Typically includes multiple calls to client, family, caregivers, legal representatives, and providers
- ✓ Includes other activities as needed:
  - Health education and coaching
  - Referrals to providers
  - Care transitions planning and follow up
  - Consultation with care providers and medical and behavioral healthcare providers

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Tier Three Services

Tier One | Tier Two | **Tier Three**

- ✓ Low level Health Home care coordination
  - Care Coordinator supports maintenance of the client's self-management skills with periodic face-to-face visits and/or phone calls
- ✓ Client may request fewer contacts
  - Movement to this tier is not for the Care Coordinator's convenience
- ✓ The client's chronic condition stabilizes and demonstrates a high level of activation in self-management of health

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Tier Three Services (cont.)

Tier One | Tier Two | **Tier Three**

- ✓ The HAP must be reviewed with every contact:
  - The HAP is the foundation of your relationship
  - Review progress toward goals
  - Identify new or unidentified care opportunities
- ✓ At least one of the six Health Home services must be provided:
  - When a client requests fewer contacts they may not want to be contacted each month so do not bill for months when no contact or no services were provided

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Billing for Services

- Contact may not occur monthly depending on the client's needs and the Health Action Plan (HAP)
  - Bill only for months when service was provided
- The HAP must be reviewed at least once during each four month activity period or more often as needed to monitor and update the goals and action steps and administer the required screenings
- Document the core service/s provided to support billing

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Let's Pause to Check for Understanding

Do you have any questions about the six core services or the 3 payment tiers?

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Outreach

Client outreach

Client enrollment materials

Consent and opting out

Client engagement

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Client Outreach

Using **"smart assignment"** the Lead Organization will provide the CCO with a list of clients who meet the eligibility requirements for Health Home services

The Health Care Authority (HCA) will send **Fee-for-Service** clients the Health Home letter and "Your Washington State Health Home Booklet"

Lead Organizations that are **Managed Care Organizations** (MCO) will send their enrollment materials to their members

Care Coordinator, support staff, or Outreach Specialist may make first contact and schedule a face-to-face visit

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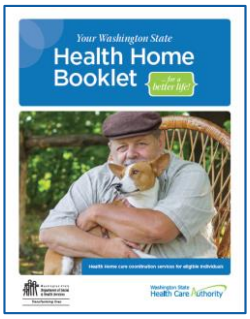
Welcome Booklet for Fee-for-Service Clients

Flyers and brochures are available under the HCA's website:

http://www.hca.wa.gov/billers-providers/programs-and-services/resources-0#care-coordinator-training



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Sample Outreach Script

Tips for effective outreach calls:

- ✓Keep it **brief**
- ✓Don't rush
- ✓Ask questions and **listen**
- ✓Ask if someone else should be present at the first visit
- ✓**Wrap up**, confirming the visit date and time
- ✓**Thank** them for their time and interest

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TRAINING

Participation Authorization and Information Sharing Consent Form

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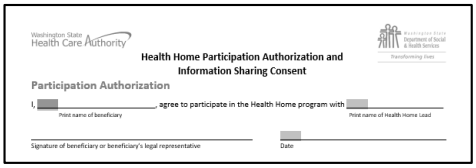
TRAINING

Part 1 of the form

Participation Authorization portion of the form must be signed



Washington State Health Care Authority

Health Home Participation Authorization and Information Sharing Consent

Washington State Department of Social & Health Services

Transforming lives

Participation Authorization

I, _____, agree to participate in the Health Home program with _____

Print name of beneficiary — Print name of Health Home Lead

_____ _____

Signature of beneficiary or beneficiary's legal representative — Date

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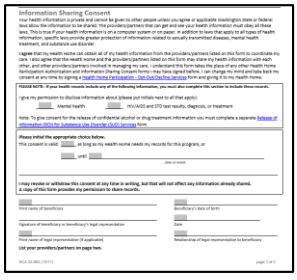
Part 2 of the form:

Information Sharing Consent portion of the form must be signed in order to release information to any party listed on the back of the form



Information Sharing Consent

Your health information is private and cannot be given to other people unless you agree or applicable Washington state or federal laws allow the information to be shared. The providers/partners that can get and see your health information must obey all these laws. This is true if your health information is on a computer system or on paper. In addition to laws that apply to all types of health information, specific laws provide greater protection of information related to sexually transmitted diseases, mental health treatment, and substance use disorder.

I agree that my health home can obtain all of my health information from the providers/partners listed on this form to coordinate my care. I also agree that the health home and the providers/partners listed on this form may share my health information with each other, and other providers/partners involved in managing my care. I understand this form takes the place of any other Health Home Participation Authorization and Information Sharing Consent forms I may have signed before. I can change my mind and take back my consent at any time by signing a Health Home Participation – Opt-Out/Decline Services form and giving it to my Health Home.

PLEASE NOTE: If your health records include any of the following information, you must also complete this section to include those records.

I give my permission to disclose information about (please put initials next to all that apply):

_____ Mental health _____ HIV/AIDS and STD test results, diagnosis, or treatment

Note: To give consent for the release of confidential alcohol or drug treatment information you must complete a separate Release of Information (ROI) for Substance Use Disorder (SUD) Services form.

Please initial the appropriate choice below.

This consent is valid: _____ as long as my Health Home needs my records for this program, or

_____ until _____

date or event

_____

I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared.
A copy of this form provides my permission to share records.

_____ _____

Print name of beneficiary — Beneficiary's date of birth

_____ _____

Signature of beneficiary or beneficiary's legal representative — Date

_____ _____

Print name of legal representative (if applicable) — Relationship of legal representative to beneficiary

List your providers/partners on page two.

HCA 22-002 (12/17) page 1 of 2

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Page 2 of the form:

Print name of Health Home beneficiary: _____

List the name of participating providers/partners	Beneficiary Gives Consent		Beneficiary Withdraws Consent	
	Date	Initials	Date	Initials
Past Care Coordination Org. (CCO)/Lead				
Past CCO/Lead				

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Participation Authorization and Information Sharing Consent Form

- Best practice is to take it to face-to-face visits and appointments to amend as needed
  - If able, scan a copy (both pages) into the client electronic health record (EHR) for other staff and providers to access
- Use the back of the form to add and delete providers
  - Enter the date and have the client initial

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Outreach to Foster and Adoptive Children

- The DSHS Fostering Well Being Unit (FWB) must be contacted before contacting foster parents
  - Foster parent contact information is confidential and can only be released by the Department of Children, Youth, and Families Social Worker
  - The FWB unit can identify the social worker assigned to the child so care coordinators can reach out to them regarding the child
- Adoptive Children
  - The Foster Care Medical Team at HCA can also assist with identifying the child's adoptive parents. Call the HCA's Customer Service line at: 1-800 562-3022 Ext. 15480 (you will need your agency's NPI number in order to speak to a representative)
- Most adoptive and foster care children receive managed care through Coordinated Care of Washington

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Special Release of Information for Adolescents

Children ages 13 through 17 years must sign a consent form to release their information related to:

- Mental health
- Reproductive health
- Chemical dependency

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Adolescent Consent Form

For children 13–17 years of age

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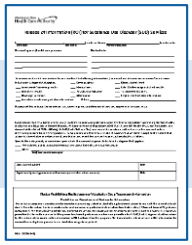
TRAINING

Release of Information Form for Substance Use Disorders



HCA form 13-335 (3/16)

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TRAINING

Tribal Relations

- Each Tribe is a sovereign nation
- Work with your Lead to determine the protocol for contacting reservation residents
  - Each tribe will have a different protocol and contact people
  - Always respect tribal sovereignty when entering tribal lands/reservations even if your client is not a tribal member
  - At a minimum, on weekends and after hours, stop by law enforcement and let them know who you are and who you are needing to contact

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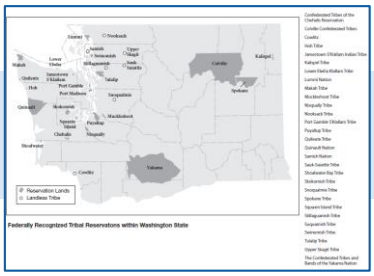
Federally Recognized Tribal Reservations



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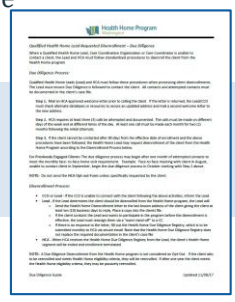
Due Diligence



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Due Diligence (cont.)

Three telephone calls must be attempted: note in narrative

One introduction letter must be mailed

Document your actions and discuss with your Lead if unable to contact

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Opting Out

Clients have the right to:

- Opt out of the program before services begin
- Opt out at any time after services begin
- If your client requests to re-enroll in the program the Care Coordinator can contact the Lead to request re-enrollment

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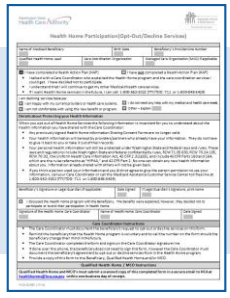
Opt Out Form

- The client may complete and sign the form or the Care Coordinator or allied staff may complete the form on the client's behalf
- Mail a copy to the client because it contains information on how to re-enroll in the program if they change their minds



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Client Vignettes

We will use these vignettes throughout our training activities:

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TRAINING

Small Group Work

Review the profile of your client

Record the following on your flip chart:

- Client profile: briefly **describe** your client
- What actions would you take to reach out to the client and **engage** them in the program?

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Let's Pause to Check for Understanding

What experiences have you had when you have initially contacted new clients in the past? What worked or didn't work?

Do you have any questions?

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PRISM

A Care Coordination Tool

Predictive **R**isk **I**ntelligence **S**yste**M**

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Today's Presenter

Candace Goehring, MN, RN

- Director of Residential Care Services
- Dept. of Social and Health Services
- Aging and Long Term Support Administration

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PRISM

A Decision Support tool designed to support care management interventions for high-risk clients

- ✓Identification of clients most in need of comprehensive care coordination based on risk scores developed through predictive modeling and other indicators
- ✓Integration of information from medical, social service, behavioral health, and long term care payments and assessment data systems
- ✓Intuitive and accessible display of client health and demographic from administrative data sources

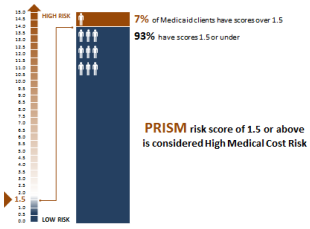
77

Risk Tools

1. **Future Medical Cost Risk Score**
   Calculates expected level of future costs relative to a comparison group
2. **Inpatient Admission Probability**
   Calculates the probability of an inpatient admission in the next 12 months
3. **Mental Illness Flag**
4. **Substance Use Flag**

78

Defining High Future Medical Cost Risk



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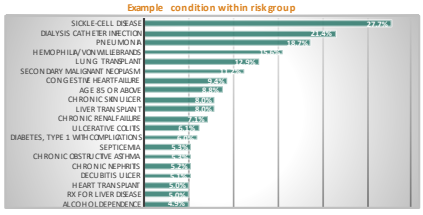
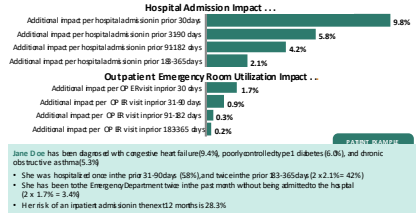
Prospective Inpatient Admission Probability



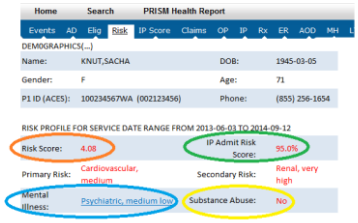
80

Prospective Inpatient Admission (cont.)



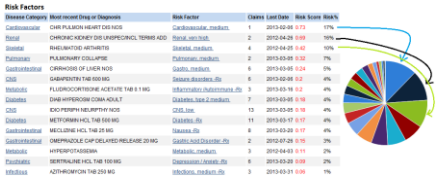
81

Risk Profile



82

Risk Factors



83

Risk Factor Methodology for Identifying Eligible Clients:

- Medical expenditure risk factors include the following:
  - Age
  - Gender
  - Diagnoses
  - Prescriptions

Note: the Health Home program was designed only to identify the top 5-7% of the Medicaid population and cannot accommodate everyone who could benefit from care coordination

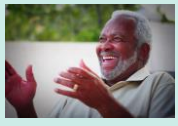
84

Why Do We Focus on Risk?


85

What We Have Learned About Dual-Eligible Clients

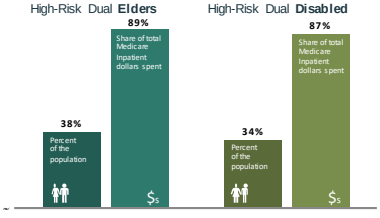
Chronic conditions are more prevalent for dual-eligible clients




86

Duals with High Risk Scores

Disproportionate share of Medicare Inpatient costs



87

Pharmacy Profiles: High-risk Dual Eligibles

Persons with at least 1 month of dual Medicaid/Medicare enrollment in SFY 2010

THERAPY CLASS	SUMMARY DRUG DESCRIPTIONS	Elders Percent	Disabled Percent
Cardiac	Ace inhibitors, beta blockers, nitrates	85.5%	69.5%
Pain	Narcotics	61.3%	72.2%
Depression/Anxiety	Antidepressants, antianxiety	61.2%	73.2%
Hyperlipidemia	Antihyperlipidemics	51.2%	43.2%
Gastric Acid Disorder	Cimetidine	58.7%	60.2%
Diabetes	Insulin, sulfonylureas	38.1%	34.8%
Asthma/COPD	Inhaled glucocorticoids, bronchodilators	36.0%	41.1%
Seizure disorders	Anticonvulsants	28.0%	48.0%
Psychotic illness/Bipolar	Antipsychotics, lithium	20.1%	31.8%
Alzheimer's	Tacrine	13.9%	1.5%
Anti-coagulants	Heparins	18.3%	11.5%
Multiple Sclerosis/Paralysis	Baclofen	11.5%	33.8%

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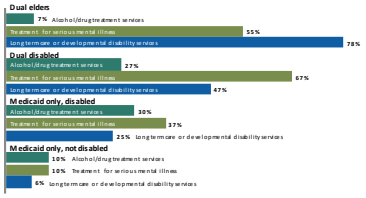
Why Focus on Coordination Across Delivery Systems?

High-risk clients are likely to have service needs in multiple delivery systems



89

Accessing PRISM

90

PRISM User Responsibilities

- Your Lead Organization's PRISM coordinator will:
  - Instruct you on the registration process
  - Determine the type of access you receive
- Keep contents confidential and private
- Don't share your password
- Annually update your agency's IT security and HIPAA confidentiality training
- Contact your Lead Organization if your profile information changes

91

PRISM Use

- Only access, use, and disclose the minimum amount of data to perform your job and assist the client
- Report suspected or actual security breaches to your Lead Organization immediately
- PRISM is monitored continuously and access may be suspended or terminated for unusual or potentially unauthorized activity
- Violations of RCW and HIPAA may result in severe criminal or civil penalties

92

How Do I Use PRISM in my Role as a Care Coordinator?

93

Uses of PRISM

- Triaging high-risk populations to efficiently allocate scarce care management resources
- Identification of health risk indicators for high-risk patients
- Identification of behavioral health needs
- Medication adherence monitoring
- Identification of other potential barriers to care
  - Homelessness
  - Hearing impairment
  - Limited English proficiency

94

Uses of PRISM (cont.)

- Access to treating and prescribing provider contact information for care coordination
- Creation of health summary reports to share with providers
- Identification of care opportunities

95

Keys for Effective PRISM Use

- **Be bold**! You can't hurt anything
- Check eligibility tab to determine completeness and coverage gaps
- Consider possibility of false positive diagnoses
  - Can include "Rule Out" diagnoses
  - Diagnoses reflect standard uses of medications, not off-label uses

96

Keys for Effective PRISM Use (cont.)

- Consider lag times – PRISM updates weekly but providers may be slow to submit their claims
- Out of pocket payments or private insurance payments will not display in PRISM
- Alcohol and drug treatment services are redacted and will not appear. If alcohol or substance use have been noted by a provider in other health services events then a flag (yes) will display

97

Keys for Effective PRISM Use (cont.)

- Mental Health: this is created as a flag that the client may need mental health services. It is based on either prescriptions or diagnoses from other health service events.
- Tailor how you will use PRISM data with your client
  - How much information will you share?
  - Will this information serve to activate your client and reinforce their changes?

98

PRISM Data

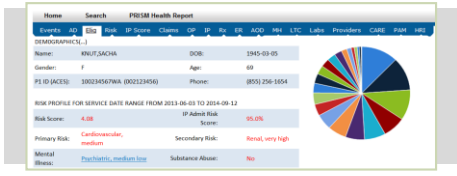
99

PRISM Screens

Events	Event timelines for Inpatient, Outpatient, ED, Medicare and Medicaid
AD	Drug adherence timelines for all prescription drugs
Risk Factors	Key Medical and Behavioral Health Risk Areas
Eligibility	Detailed eligibility and demographic data
Claims	All medical claims and encounters
OP	Outpatient claims
RX	Prescriptions filled
IP	Inpatient admissions
ER	Outpatient emergency room visits
LTC	Long term care services
Lab	Laboratory
Providers	Provider list with links to contact information
MH	Mental health services
CARE	Long-term care functional assessments
HRI	Health risk indicators (for Children)

100

Let's Look at a De-identified Case



101

TRAINING

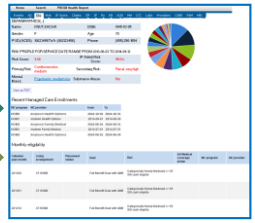
PRISM Screens

PRISM can assist you in your care coordination duties

102

Use the Eligibility Screen to Verify Current Coverage and Gaps

- Has the client been previously covered by another MCO?
  - If so there may be a HAP already in the system
- Is the client currently eligible?
- Are there any gaps in coverage?



103

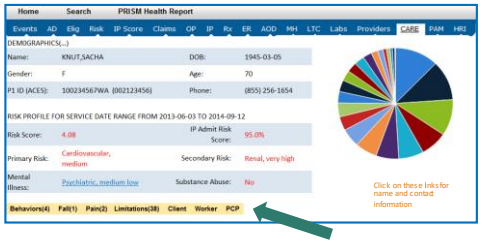
Identifying Long Term Care Services: the CARE Tab

104

Long Term Care Payments

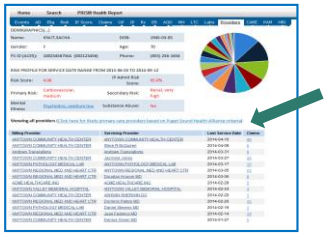
105 Payments may also be located under Claims screens

Identifying the LTSS Case Manager



106

Another way to find the PCP



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PRISM Health Report

- See your training manual for an example for John Doe
- Value of these reports:
  - Helps promote self-management
  - Supports the client as their own historian
  - Provides a snapshot of the various look-back periods for the various screens
  - Promotes continuity of care between health care providers

108

Let's Pause the Video to Check for Understanding

- Have you used PRISM in the past and what was your experience? How did you use the information about your client?
- Do you have any questions?

109

How to Make a Referral

- **If a Care Coordinator identifies someone who may benefit from Health Home services the Care Coordinator may:**
  - Contact your Lead Organization
    - The Lead Organization can email the Health Home program to see if the client is eligible and/or is already enrolled with a Health Home Lead
  - If the client does not have a PRISM score of 1.5 consider if there are recent major changes to health which may qualify them
  - Refer the case to their Lead Organization and include any additional information that may support the referral

110

How to Make a Referral (cont.)

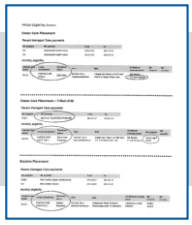
The Lead will submit the referral to the Health Care Authority (HCA)

- The Lead may be aware that the client is already assigned to another CCO
- The Lead may refer the case to a different CCO if HCA approves services
- The HCA may not approve the services
- The HCA may choose to refer the case to another Lead

111

Reminder: Contact Requirements for Foster Children

- To identify if a child is receiving foster care check the PRISM eligibility screen
- Contact Department of Children, Youth and Families, not the foster parent for initial outreach



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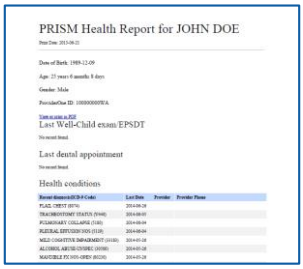
TRAINING

Final Thoughts on PRISM

- Use this tool to optimize Health Action Planning and client support
- Report all suspected or actual security breaches to your Lead Organization immediately
- PRISM is monitored continuously and access may be suspended or terminated for unusual or potentially unauthorized activity

113

Final Thoughts on PRISM (cont.)


PRISM Health Report for JOHN DOE

Last Well-Child exam/EPSDT

Last dental appointment

Health conditions

- Review your clients only: violations of RCW and HIPAA may result in severe criminal or civil penalties
- Do not release the client's reports without the client's written consent to release PRISM information

114

TRAINING

Where to Turn for Assistance

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Where to Turn for Assistance

Contact your Lead Organization

PRISM Support (DSHS Research and Data Analysis)
prism.admin@dshs.wa.gov

Health Care Authority Health Home Program
healthhomes@HCA.wa.gov

116

Practice Using PRISM

Let's return to our vignettes and begin our small group activity

117

TRAINING

Small Group Work

Navigate and review the Excel spreadsheet to analyze your client's use of services

- What is PRISM Risk Score and IP Admit Risk Score?
- What did you note about your client in reviewing the screens in PRISM?
- What issues or gaps in care* did you identify that you would like to discuss with your client?

*Gaps in care means the identification, coordination, and processing of needed referrals to meet a client's medical, behavioral health, and social service needs.

118

Let's Pause to Check for Understanding

If you have used PRISM in the past which screens did you find most helpful?

Do you have any questions?

119

Motivational Interviewing and Coaching

120

The Spirit of Motivational Interviewing (MI)

- Empathic "way of being"
- Collaborative – Partnership of experiences
- Evocative – Draws out, elicit ideas, identifies barriers, and explores solutions
- Encourages autonomy and provides support

121

Engagement – Setting the Agenda

Begin with an attitude of curiosity and a desire to understand more

Learn how the client's behaviors or concerns fit into the person's situation or world view

Be transparent and communicate your intentions and purpose

122

Join the Client on their Health Path

Explore:

123

Join the Client on their Health Path (cont.)

Five Steps for Success:

124

Keys to Successful Care Coordination

- Meeting the client where they are
- Engagement
- Collaboration
- Consistent and regular contacts
- Transitional care supports
- Confidence and skill building for self-management of chronic disease/s

125

The Patient Activation Measure® Coaching and Action Plan Development

126

Review of the Patient Activation Measure®

The PAM[1] is a behavior measurement tool that

- Reliably measures activation and the behaviors that underlie activation
- Provides insight into how to improve unhealthy behaviors and grow/sustain healthy behaviors
- Allows us to improve activation levels /behaviors, lower medical spending and improve health

[1] All references to the Patient Activation Measure in this presentation are the property of Insignia Health (copy and trademark). Parts of this presentation were adopted from Insignia Health training materials.

127

Types of PAMs

- Patient Activation Measure – PAM®
  - assesses the client's activation level
- Caregiver Activation Measure – CAM®
  - assesses the caregiver's activation level in caring for their client
- Parent Patient Activation Measure – PPAM®
  - assesses the parent's activation level in caring for their child

Insignia Health®

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TRAINING

What is Client Activation?

Having the knowledge, skills, emotional support, and belief to:

- Self manage health
- Collaborate with providers
- Maintain function and prevent declines
- Access appropriate high quality care

129

Administering the PAM

Emphasize that the tool is a **health** survey

It is all about helping the client

It is neither used to judge nor reduce or deny any benefits

130

PAM 13 Question Survey

Let's review the 13 Patient Activation Measure Statements now

131

TRAINING

Tips for Administering the Assessment Tool

- It does not require a face-to-face contact to complete
- This survey can be administered over the telephone
- It could be mailed and completed in advance of the first face-to-face visit
- Check with your Lead regarding their policies related to administering this and other assessments

132

Tips for Administering the Assessment Tool (cont.)

- Some people do a better job completing it themselves
- Consider asking the caregiver to complete a CAM if the client is unable to respond
- If a client refuses offer again at a later date
- You could provide a copy of the tool and ask the questions and record the answers
  - This is helpful for clients with limited reading ability

133

Tips for Administering the Assessment Tool (cont.)

- Ask the client how much they agree or disagree with the 13 statements
- Always start with strongly disagree to strongly agree
- Always ask the questions in order
- Do not change the questions
- Statements become increasingly more difficult to agree with

134

Tips for Administering the Assessment Tool (cont.)

- Do not discuss responses to the statements while administering the PAM – this may improve scores
- Allow the client to consider the statements, silence may indicate that they are thinking about their response

135

Tips for Administering the Assessment Tool (cont.)

- If a client is unable to complete the survey or refuses document in the HAP
  - The date the assessment was offered and declined
  - If known, the reason the assessment was not administered
- When a client, caregiver, or parent do not complete the tool offer it at a subsequent visit

136

Tips for Administering the Assessment Tool (cont.)

- Use the client's responses as a springboard for further discussion (only after they have completed the survey)
  - Consider using the responses to individual statements as a starting place for discussing health concerns which the client may wish to address in their HAP

137

Interpret PAM Responses

Client Response	Interpretation
Agree Strongly	Yes – the question is true about me. This is a **definite** "yes".
Agree	**Sometimes** this is true about me or is **potentially** true about me.
Disagree/Strongly Disagree	This is **not true** for me.
NA	This does **not apply** to me. I do **not know** how to answer. I **refuse** to answer.

138

Scoring

- Scoring is the same for the PAM, CAM, and PPAM
- Ask your Lead Organization for the scoring guide
  - Most Leads have software that will score the tool
- The activation **score** is converted to an activation **level**

139

PAM Segmentation Characteristics

Level 1: Disengaged and overwhelmed

Starting to take a role. Clients do not yet grasp that they must plan to take an active role in their own health. They are disposed to being passive recipients of care.

Level 2: Becoming aware, but still struggling

Building knowledge and confidence. Clients lack the basic health related facts or have not connected these facts into larger understanding of their health or recommended health regimen.

140

PAM Segmentation (cont.)

Level 3: Taking action

Clients have the key facts and are beginning to take action but may lack confidence and the skill to support their behaviors.

Level 4: Maintaining behaviors and pushing further

Clients have adopted new behaviors but may not be able to maintain them in the face of stress or health changes.

141

PAM Segmentation Characteristics

Roughly 45 to 50% of all Medicaid clients who have completed the measure score at a Level 1 or Level 2

- Level 1: Disengaged and overwhelmed
- Level 2: Becoming aware, but still struggling

Review the client's activation score and level to tailor coaching that is appropriate to the client

142

Elicit the Client's Story Using Responses to PAM Questions

Select an item where their answers begin to move away from strongly agree. Help the client discover:

- What led them to select the response?
- Why this level and not a lower level?
- What would it take to reach the next level?
  - Is this something we could work on together?

143

Elicit the Client's Story Using Responses to PAM Questions (cont.)

With self-reflection the client makes an assessment of:

- What the problem is
- What will have to happen to alter this assessment
- How the Care Coordinator can coach the client to pursue behavioral changes

144

Tailor Your Coaching

Use responses to individual PAM items to get them to explain what is going on.

The client will make statements indicating what they think are the barriers or challenges.

Use perceived barriers to jointly problem solve throughout the coaching process.

145

Analyze the Results Incorporating Motivational Interviewing Techniques

Notice when your client begins to disagree or strongly disagree with the statements

This can be a good place to begin discussion about identifying areas where the client or representative may want to consider the type of goal they may be interested in pursuing

Consider using motivational interviewing techniques to draw the client or representative out

146

Motivational Interviewing Strategies

Start with where the person is and try to understand how the client understands their own situation

Be empathetic and ask open ended questions

Listen and do reflective listening

- "It sounds like you are feeling…"
- "So, you are saying that you believe…"

147

Motivational Interviewing Strategies (cont.)

Express acceptance and affirmation of the client's freedom of choice and self-direction

Elicit and selectively reinforce the client's own self motivational statements, expressions of problem recognition, concerns, desire, intention to change, and ability to change

148

PAM Activation Level 1

GOAL
Build self-awareness and confidence

Examples

- Self-monitoring and awareness (e.g. how much they walk or how they cope with stress)
- Start pre-behaviors (e.g. reading labels on food)
- Cope with stress
- Understand their role in the care process

149

PAM Activation Level 2

GOAL
Increase knowledge, confidence, and initial skill development

Examples

- Make sure the knowledge dots are connected
- Start with small behavioral steps (one step at a time)
- Stress management and coping skills
- Build problem solving skills

150

PAM Activation Level 3

GOAL
Initiation of new behaviors and develop problem solving skills

Examples
- Initiation of specific realistic behaviors (e.g. walking 10 minutes 3 times a week)
- Problem solving as it relates to the issues that emerge with the new behavior goals

151

PAM Activation Level 4

GOAL
Maintain behaviors and techniques to prevent relapse

Examples
- Build confidence for coping and problem solving when situations throw them off track; self-monitor for those situations (e.g. new staff at the doctor's office)
- Plan for handling a specific type of situation (e.g. using medications while traveling)
- Problem solve together

152

Perspectives on the PAM

The initial PAM score can be higher than subsequent PAM scores
The client does not know what they do not know

It is important to place the surveys side by side over time and work with the client on changed responses
Look and listen for change talk and change opportunities

Anticipate if the client may experience a decline or improvement in score to coach and support them
Be aware of individual successes and failures and how they impact confidence with developing new or different skills

153

Where Do I Get Copies of the Tools?

Lead Organizations are required to purchase a license for these products through Insignia

For copies of the PAM, PPAM and CAM, the translated tools and scoring guide contact your Lead to get Insignia's:

- Website address
- User name
- Password

154

Website Hosting PAM Versions

Ask your Lead Organization for the following to access this site:

URL: https://healthhomes.insigniahealth.com
User Name: - - - - -
Password: - - - - -

155

PAM® Small Group Work

- What is the PAM® **score** for your client?
- What is the client's or parent's **Level** of Activation?
- What did you note about his/her **responses** to the PAM/PPAM®?
- If available should the **caregiver** complete the CAM®?
- How would you begin to work with your client in relation to their responses and **Level of Activation**?

156

Let's Pause to Check for Understanding

How will awareness of a client's PAM level help you work with your client?

Do you have any questions?

157

Goal Setting

Moving Toward Health Action Planning

158

Moving Toward Health Action Planning

Consider the client's responses by reviewing and discussing the activation measure results

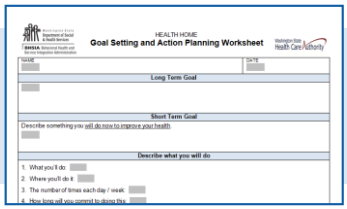
Responses may provide a clue as to changes the client would like to make

Consider using the Goal Setting and Action Planning Worksheet

159

A Tool for Starting the Conversation

The Goal Setting and Action Planning Worksheet


HEALTH HOME
Goal Setting and Action Planning Worksheet
NAME
DATE
Long Term Goal
Short Term Goal
Describe something you will do now to improve your health
Describe what you will do
1. What you'll do
2. Where you'll do it
3. The number of times each day / week
4. How long will you commit to doing this

160

TRAINING

Coaching and Action Planning

Goal Setting and Action Planning Worksheet

- Start where the client is
- Determine what the client wants to change
- The action plan is negotiated and tied to the discussion about the level of activation

161

Coaching and Action Planning (cont.)

Goal Setting and Action Planning Worksheet

- The action plan is something achievable given the client's level of activation
- At Levels 1 and 2 action plans focus on knowledge, belief, awareness and pre-behaviors
- At Levels 3 and 4 action plans focus on the initiation of new behaviors and maintaining behaviors

162

Developing an Action Plan

Coach the client to select the Action Steps with the least number of barriers and prioritize them

Save the list of Action Steps so alternatives can be tried if the first ones are not successful; reassure client that many problems are not easily solved and may take time and multiple approaches

163

Develop Action Steps

Describe

- What the client has agreed to do
- What the Care Coordinator has agreed to do
- Where they will do it
- How often(each day/week)?
- For how long?

164

Questions to Consider

How important is it for you right now to…? On a scale from 0 - 10… what number would you give yourself?

0_____10

CONVICTION SCALE

If you did decide to change, how confident are you that you would succeed? On a scale from 0 - 10… what number would you give yourself?

0_____10

CONFIDENCE SCALE

If you did decide to change, how ready are you to make this change? On a scale from 0 - 10… what number would you give yourself?

0_____10

READINESS SCALE

165

Coaching and the Health Action Plan

Use a coaching for activation approach to guide the client to:

- Appropriate choices
- Attainable goals
- Action steps
- Improved health

166

The Health Action Plan (HAP)

Establishes:

- Client and Care Coordinator identified:
  - Long term goal
  - Short term goal/s
  - Action steps

167

Key Skills for Health Action Planning

Demonstrate positive belief in the client's ability to take an active role to accomplish appropriate goals and action steps

Emphasize stress management and coping and resiliency skills

Ask the client to recall a former success: how did it feel?

168

Key Skills for Health Action Planning (cont.)

- Elicit the client's story
- Build rapport
- Obtain a behavioral history, including past attempts to change behavior
- Identify barriers
  - Use open-ended questions
  - Focus on feelings
  - Use reflections

169

Analyze!

- **What do you think drives poor health and high costs for your client?**
- 85% of avoidable costs are due to behavioral, not medical factors

Consider:

- Client's perspective
- Results from assessment and screening tools
- PRISM Risk Factors
- Client's Level of Activation

170

Use Active and Reflective Listening

Assure them that you can see their point of view

Acknowledge the struggles or difficulty involved

Acknowledge their success and their skills, abilities, and strengths
- Thoughts
- Beliefs and values
- Behaviors

Use **you** statements – strength based approach

"You sound determined."

171

Consider What Values Lie Behind These Statements

- I want to feel better
- I want to be more independent
- I want to be able to attend church with my family
- I want to see my grandchildren grow up

Keep these in mind so you can later link these values to their long term goals, short term goals, and action steps

172

Emphasize Problem Solving

A Health Action Plan requires addressing problems through "action steps"

Adults learn best by "doing" rather than through reading materials or hearing information

Working through a problem using health coaching increases and enhances retention

Identify their capacity for change and self-efficacy

173

Identify Barriers to Change

- Ambivalence?
- Understanding?
- Support system?
- Energy levels/sleep quality/pain?
- Depression?
- Health literacy?
- Financial?
- Confidence?
- Social isolation?

174

Explore Possible Solutions

ASK the client to **review** possible solutions, but not make a decision just yet…

ASK the client to **identify** possible solutions, "do you have any ideas on how you could solve this problem?"

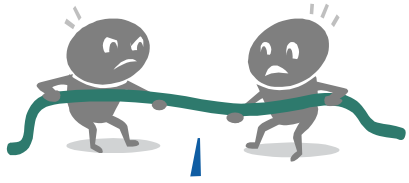
ASK the client if they would like you to **share** your thoughts and/or provide ideas using Health Home resources.

ASK the client if they would like you to **provide** additional health education information; if so, review and discuss the information with them at the next visit.

175

Resistance

It's human nature! Taking one side of a conflict can cause a person to take the opposite stance. It's normal…



176

Behavioral Change

Trying to convince another person to make a behavior change can actually cause the person to be **less likely** to make a change.

Even if you are successful in convincing someone to make a behavioral change, the change is not likely to last.

177

Resist the Righting Reflex Exercise

Pair up and take turns as the speaker and the listener

Speaker

Share your thoughts and feelings about a behavioral change you have thought about making or a change you previously made but are having trouble maintaining

Listener

- Ask open-ended questions
- No closed-end questions
- Neither agree nor disagree
- Avoid sharing your opinions or experiences

178

How Did It Go?

- What was it like to be the listener… did you want to interject your experiences or thoughts?
- Were there times when you wanted to jump in and offer advice or "fix it"?
- What was that like for you as the speaker… did you feel understood?
- How did it feel to have someone place all of their focus on you and your concerns for even 5 minutes?
- What did you learn from this interaction about your own style?

179

Cultivate a Sense of Hope

Demonstrating a **positive belief** in your client has a positive impact on the client's ability to accomplish their goals and action steps and sustain behavioral change.

Hope is one of the greatest contributions you make to your client as their Care Coordinator.

180

The Day in Review

Health Home fundamentals

Client outreach and engagement

PRISM

The Patient Activation Measure

Goal setting and action planning: moving toward the Health Action Plan

181

Let's Pause to Check for Understanding

How is the role of a Care Coordinator different than those you have had in the past?

What benefits do you see for your clients who engage in the program?

Do you have any questions about what we covered today?

182

Planning for Day Two

- Start time for training
- Location
- Topics to cover
  - The Health Action Plan
  - Comprehensive Care Transitions
  - Documentation
  - Quality Assurance
  - First Meeting
  - Safety
  - Resources and websites
  - Ongoing training requirements

183

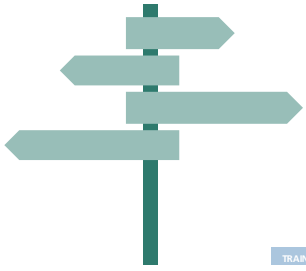
Welcome to Day Two

Do you have any questions about what we coveredon Day One?

- HH Fundamentals
- Outreach and engagement
- PRISM
- PAM
- Moving toward health action planning

184

The Health Action Plan



TRAINING

185

Most People Desire Better Health and Quality of Life

Each client is in charge of their own health

Their own Health Action Plan, and

Whether or not they make lifestyle changes

186

Help Identify a Long Term Goal

Use a **person-centered** approach to help the client identify:

- What would they like to happen as a result of their health changes?
- What would they like be able to do that they can't currently do?
- What their level of activation is and how it will help or hinder their ability to achieve their goal/s?

187

Help Identify a Long Term Goal (cont.)

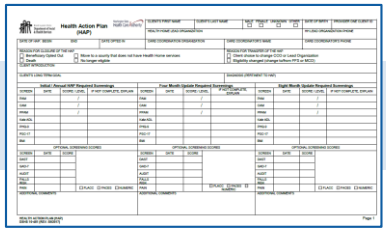
Long term goals may relate more to social goals but by achieving them the client may:

- Reduce medical costs
- Slow the progression of chronic disease
- Delay the onset of another chronic disease
- Reduce avoidable ED visits and hospital admissions and readmissions

188

Health Action Plan: Page 1

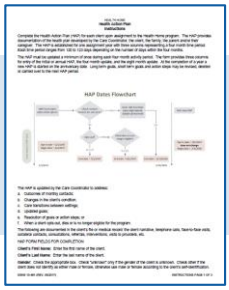
Note: most Lead Organizations have a data platform that is used to capture the HAP. These platforms can print the HAP but it may not look like the paper form.


Health Action Plan (HAP)

189

TRAINING

HAP Instructions



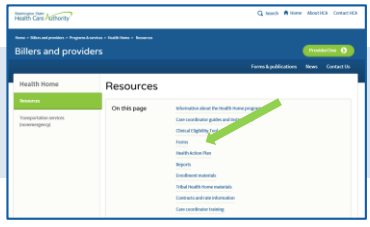
Additional Training on the HAP

- Your Lead/s will provide operational training on how to use their software programs
- Don't hesitate to ask for technical assistance
- Meetings are sponsored by the Leads to supplement this training
- DSHS sponsors monthly webinars and a quarterly newsletter with information related to the program and your work

HAP Form and Instructions

The revised HAP and Instructions are located at the HCA Website:

https://www.hca.wa.gov/billers-providers/programs-and-services/resources-0



HAP Form Instructions

Each HAP spans a 12 month enrollment period consisting of three separate four month updates or activity periods

All other documentation goes in the client record or file

193

TRAINING

HAP Form Instructions (cont.)

The Health Action Plan is updated and modified at each monthly contact by the Care Coordinator and when necessary to support a care transition or when the client opts-out of the Health Home program.

The Health Action Plan is updated and modified as needed according to:

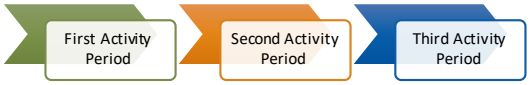
- A change in the client's condition
- New immediate goals to be addressed
- Completion of a short term goal and action steps

194

What is an Activity Period?

195

Activity Periods



- There are three activity periods in a yearly (12 month) cycle
- Each activity period is four months
- There are 120 to 123 days within an activity period
  - Number of days in a month varies from 28 or 29 days for February and 30 to 31 days for other months

196

TRAINING

Activity Periods Example

February March April May

June July August September

October November December January

Start date of next HAP is February 1,2022

197

Individual or Group Activity

Activity Periods Worksheet

198

TRAINING

Worksheet 3: Activity Periods

If the client opts in May 1, 2021:

1. What are the dates for the first activity period?
2. What are the dates for the second activity period?
3. What are the dates for the third activity period?
4. What is the start date for the next HAP year cycle?

January February March April May June July August September October November December

Worksheet 3: Activity Periods

May 1 thru August 31

September 1 thru December 31

January 1, 2021 thru April 30

May 1, 2022

January February March April May June July August September October November December

Worksheet 3: Activity Periods

If the client opts in July 13, 2020:

1. What are the dates for the first activity period?
2. What are the dates for the second activity period?
3. What are the dates for the third activity period?
4. What is the start date for the next HAP year cycle?

January February March April May June July August September October November December

Worksheet 3: Activity Periods

July 13 thru November 12

November 13 thru March 12, 2021

March 13 thru July 12

July 13, 2021

January February March April May June July August September October November December
202

Worksheet 3: Activity Periods

1. What is the end date of the HAP if the client notifies the Care Coordinator that he no longer wants to participate in the program during a phone call on May 10, 2020?

   May 10, 2020

2. The Care Coordinator made several calls to the client and sent a letter with no response from the client and the Lead approves closure of the HAP. The letter was mailed to the client on August 13, 2020 and the final call was made on August 17, 2020. What is the end date for the HAP?

   August 17, 2020

203

HAP Form Instructions (cont.)

Demographic data fields for name, gender, date of birth and ProviderOne ID

Date the HAP begins

Date the client Opts-in

- This is the date the client agrees to participate in the program and begins development of the HAP.
- This date becomes the client's anniversary date. It triggers the start of a new HAP for the next HAP reporting year.

204

TRAINING

HAP Form Instructions (cont.)

Date the HAP ends:

- At the end of a one year cycle (do not prepopulate this field)
- The day the client opts out of the program
- The date the HAP ends for other reasons as listed in the Reason for Closure of the HAP data field (check the appropriate box if one of the reasons apply)


Health Action Plan (HAP)

205

HAP Form Instructions (cont.)

If a client is transferring for one of the reasons listed, then do not enter a HAP end date as the HAP is still active until the end of the one year cycle even though it may be transferred.

Reasons for transfer of the HAP include:

- Client choice to change CCO or Lead Organization
- Eligibility changed:
  - Client was enrolled with a Managed Care Organization (MCO) and transferred to a Fee-for-Service (FFS) Health Plan
  - Was enrolled with as FFS and transferred to an MCO Health Plan


Health Action Plan (HAP)

206

HAP Form Instructions (cont.)

Options for gender include:

Because clients have a right to change Lead Organizations or Care Coordination Organizations the names and phone numbers are provided

207

HAP Instructions (cont.)

Write a brief statement about the client

Develop a long term goal that is person-centered, based on what the client wants to achieve

Enter the diagnosis or diagnoses that are pertinent to the long term goal

208

Help the Client Identify Long Term and Short Term Goals

"Physically, what can you do best?"

"When are you strongest?"

"Who do you contact when you aren't feeling well?"

"Which health concerns have the biggest impact on your life?"

"What are some ways you may increase your wellness?"

209

HAP Form Instructions (cont.)

Required screenings: enter the dates and scores of the screening on the HAP

- PHQ-9 – Patient Health Questionnaire (Depression Screening) or
- Pediatric Symptom Checklist – 17 (PSC-17) ages 4-17
- BMI – Body Mass Index
- Katz Activities of Daily Living
- Patient Activation Measure
  - Patient Activation Measure (PAM) or
  - Caregiver Activation Measure (CAM) or
  - Parent Patient Activation Measure (PPAM)

210

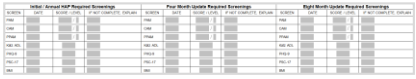
HAP Form Instructions (cont.)

Enter the date the screening was completed or offered but declined

Enter the activation score and level of activation for each type of activation measure completed

If the client, caregiver or family decline or are unable to complete the screening enter the date and the reason the screening was not completed

Screening must be completed at least once during each four month activity period or more often as clinically indicated



211

Required Screenings

- Patient, Parent or Caregiver Activation Measure – PAM® from Insignia
- PHQ-9: Patient Health Questionnaire with nine questions to screen for depression and suicide (age 18 & older)
- PSC-17: Pediatric Symptoms Checklist for children (age 4 – 17)
- Katz ADL: activities of daily living to take care of themselves
- BMI: Body Mass Index to determine if they are a healthy weight

Note: the client, parent and caregiver reserve the right to decline to complete any of these assessments

212

Patient Activation Measures

The PAM is required for clients

- Note the date, the activation score and activation level on the HAP
- If the client cannot complete the PAM
  - Note the date the screening was offered and note the reason the PAM was not completed on the HAP OR
  - Complete the CAM or PPAM (see next slides)
  - The PAM dates may not be the same as the start date of the HAP or updates for each four month activity period

213

Caregiver Activation Measure

The CAM may be administered when the client is unable or unwilling to complete the PAM

- Caregivers may be informal or formal caregivers, or paid or unpaid caregivers
- Document in the case record the name and relationship of the person who completed the CAM
- Note the date the CAM was completed, the activation score, and activation level on the HAP

214

Parent Patient Activation Measure

The PPAM must be administered to the parent or guardian of children under the age of 18 years

- Parents include: biological, adoptive, or foster
- Note the date the PPAM was completed, the activation score and activation level on the HAP
- Document in the case record the name and relationship of the person who completed the PPAM
- If the parent or guardian declines to complete the PPAM note the date the assessment was offered and the reason the parent/guardian did not complete the screening

215

The Katz ADL: Ages 18+

Score one point for each of the six ADLs that client reports that they can perform independently without assistance

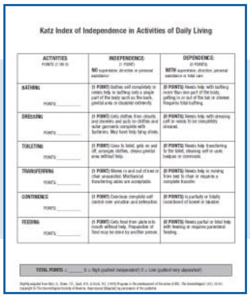
If a client indicates that they are dependent and could use assistance with two or more ADLs consider a discussion about applying for LTSS (or follow-up with case manager on any changes if client already has LTSS)

Referring the client to the DSHS Developmental Disabilities Administration or Home and Community Services Office in your area is an appropriate service for you to offer

216

Katz Activities of Daily Living (ADLs)

Link to 29 minute training video:
https://consultgeri.org/try-this/general-assessment/issue-2



Katz Index of Independence in Activities of Daily Living

ACTIVITIES POINTS (1 OR 0)	INDEPENDENCE: (1 POINT) NO supervision, direction or personal assistance	DEPENDENCE: (0 POINTS) WITH supervision, direction, personal assistance or total care
BATHING POINTS: ____	(1 POINT) Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	(0 POINTS) Needs help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing.
DRESSING POINTS: ____	(1 POINT) Gets clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	(0 POINTS) Needs help with dressing self or needs to be completely dressed.
TOILETING POINTS: ____	(1 POINT) Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	(0 POINTS) Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
TRANSFERRING POINTS: ____	(1 POINT) Moves in and out of bed or chair unassisted. Mechanical transferring aides are acceptable.	(0 POINTS) Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE POINTS: ____	(1 POINT) Exercises complete self control over urination and defecation.	(0 POINTS) Is partially or totally incontinent of bowel or bladder.
FEEDING POINTS: ____	(1 POINT) Gets food from plate into mouth without help. Preparation of food may be done by another person.	(0 POINTS) Needs partial or total help with feeding or requires parenteral feeding.

TOTAL POINTS = ____ 6 = High (patient independent) 0 = Low (patient very dependent)

217

PHQ-9 and PSC-17 Screens

Patient Health Questionnaire: nine item screening tool for depression
- 18 years and older

Pediatric Symptom Checklist: 17 item screening tool for moods and behaviors
- Ages 4 through 17 years

218

PHQ-9 and PSC-17 (cont.)

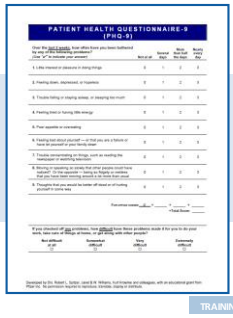
The Care Coordinator's role is to screen for possible behavioral health issues

Care Coordinator's do not diagnose, counsel, or treat; they refer to qualified professionals and behavioral health resources for further assessment and treatment

219

The PHQ-9 is a Required Screening

Your manual also contains a copy of the GAD-7


PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

220

TRAINING

Guide Sheet on Depression Screening and Suicide

- Guide Sheet offers general guidelines
  - Your agency may also have their own policies, procedures, and reporting requirements
- Interpretation of results of PHQ-9: a score of 10 or higher indicates moderate depression
  - Offer a referral to PCP or a behavioral health provider
  - If a client expresses that they have thought about suicide, have a plan, and have the means seek help immediately

221

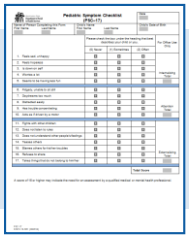
TRAINING

Pediatric Symptom Checklist – 17

- The PSC-17 must be completed for children ages 4 to 17 years of age
- The screening is completed by the parent or guardian
  - Scoring is based on the parent's report of current behaviors
- A child age 13 and over may self-administer the screening
- Note in the comment section the name of the person who completed the screening and their relationship to the child. Enter the parent's score in the HAP and note the child's score in the case narrative

222

DSHS Form 10-509 PSC-17 & Instructions



223

TRAINING

PSC-17 Considerations

The screening tool should not be used for diagnosing

A score of 15 or higher may indicate the need for further evaluation by a qualified professional

The screening tool offers three subscales for:

- Internalizing behavior
- Externalizing behavior
- Attention

224

PSC-17 Website

For translations of the tool visit the Massachusetts General Hospital website located at: https://www.massgeneral.org/psychiatry/treatments-and-services/pediatric-symptom-checklist/

MASSACHUSETTS GENERAL HOSPITAL PSYCHIATRY

225

Body Mass Index (BMI)

This is required on the HAP

- BMI chart is located in the Classroom Training Manual
- BMI is not required for children under 2 years of age
- If you are unable to get a recent or accurate weight record the BMI and make a comment in the comment box
- BMI can be used as a benchmark in helping clients create wellness goals

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TRAINING

BMI Online Charts

BMI Calculator for Children and Teens (2-19)
https://www.cdc.gov/healthyweight/bmi/calculator.html

BMI Calculator for Adults
https://www.cdc.gov/healthyweight/assessing/bmi/adult_bmi/english_bmi_calculator/bmi_calculator.html

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Additional Screenings

- AUDIT: Alcohol Use Disorders Identification Test
- DAST: Drug Abuse Screening Test
- Falls Risk: My Falls Free Plan
- GAD-7: General Anxieties Disorder test for stress
- Pain scales: FLACC, Wong-Baker or Numeric

228

HAP Form Instructions (cont.)

Optional screenings

Enter the dates and scores of the screenings on the HAP

- DAST – Drug Abuse Screening Test
- GAD-7 – Generalized Anxiety Disorder 7 item scale
- AUDIT – Alcohol Use Disorders Identification Test
- Falls Risk – My Falls-Free Plan identifies risk and provides suggestions to prevent falls
- Pain Scales – Administration of appropriate pain scale

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TRAINING

When to complete an additional screening

- Use your clinical judgment to determine the need and frequency for offering additional screenings
  - Examples:
    - If a client identifies a goal related to pain: one of the three pain screenings
    - If a client voices concerns about their use of alcohol or drugs: the AUDIT or DAST
    - If a client reports falls or fractures: falls risk
    - If a client identifies a goal to reduce stress or anxiety: GAD-7
- If the HAP includes goals or action steps related to one of the optional screenings then the screening must be offered and documented on the HAP

230

AUDIT and DAST

Alcohol Use Disorder Identification Test (AUDIT)

- Developed by the World Health Organization
- 10 multiple choice questions for alcohol only
- 95% accurate in classifying people into risk categories for SUDs
- Accurate across many cultures/nations

Drug Abuse Screening Test 10 (DAST-10)

- 10 Yes/No Questions for poly drug use
- Abstinence based screening tool-meaning there is no safe level for any drug use
- Validated for screening adults
- Places individual in a risk category for Substance Use Disorders (SUDs)

231

Falls

- More than 1 out of 4 older adults fall each year but less than half tell their doctor
- Falling once doubles the chances of falling again
- 1 out of every 5 falls result in a serious injury
- Best practice would be to ask about falls at every face-to-face visit

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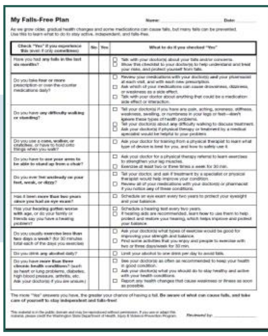
My Falls-Free Plan: A Falls Risk Screening Tool

You may find a copy in the Care Coordinator Toolkit at

https://www.dshs.wa.gov/altsa/home-and-community-services/care-coordinator-toolkit



My Falls-Free Plan Name: Date:

As we grow older, gradual health changes and some medications can cause falls, but many falls can be prevented. Use this to learn what to do to stay active, independent, and falls-free.

Check "Yes" if you experience this (even if only sometimes)	No	Yes	What to do if you checked "Yes"
Have you had any falls in the last six months?			☐ Talk with your doctor(s) about your falls and/or concerns. ☐ Show this checklist to your doctor(s) to help understand and treat your risks, and protect yourself from falls.
Do you take four or more prescription or over-the-counter medications daily?			☐ Review your medications with your doctor(s) and your pharmacist at each visit, and with each new prescription. ☐ Ask which of your medications can cause drowsiness, dizziness, or weakness as a side effect. ☐ Talk with your doctor about anything that could be a medication side effect or interaction.
Do you have any difficulty walking or standing?			☐ Tell your doctor(s) if you have any pain, aching, soreness, stiffness, weakness, swelling, or numbness in your legs or feet—don't ignore these types of health problems. ☐ Tell your doctor(s) about any difficulty walking to discuss treatment. ☐ Ask your doctor(s) if physical therapy or treatment by a medical specialist would be helpful to your problem.
Do you use a cane, walker, or crutches, or have to hold onto things when you walk?			☐ Ask your doctor for training from a physical therapist to learn what type of device is best for you, and how to safely use it.
Do you have to use your arms to be able to stand up from a chair?			☐ Ask your doctor for a physical therapy referral to learn exercises to strengthen your leg muscles. ☐ Exercise at least two or three times a week for 30 min.
Do you ever feel unsteady on your feet, weak, or dizzy?			☐ Tell your doctor, and ask if treatment by a specialist or physical therapist would help improve your condition. ☐ Review all of your medications with your doctor(s) or pharmacist if you notice any of these conditions.
Has it been more than two years since you had an eye exam?			☐ Schedule an eye exam every two years to protect your eyesight and your balance.
Has your hearing gotten worse with age, or do your family or friends say you have a hearing problem?			☐ Schedule a hearing test every two years. ☐ If hearing aids are recommended, learn how to use them to help protect and restore your hearing, which helps improve and protect your balance.
Do you usually exercise less than two days a week? (for 30 minutes total each of the days you exercise)			☐ Ask your doctor(s) what types of exercise would be good for improving your strength and balance. ☐ Find some activities that you enjoy and people to exercise with two or three days/week for 30 min.
Do you drink any alcohol daily?			☐ Limit your alcohol to one drink per day to avoid falls.
Do you have more than three chronic health conditions? (such as heart or lung problems, diabetes, high blood pressure, arthritis, etc. Ask your doctor(s) if you are unsure.)			☐ See your doctor(s) as often as recommended to keep your health in good condition. ☐ Ask your doctor(s) what you should do to stay healthy and active with your health conditions. ☐ Report any health changes that cause weakness or illness as soon as possible.

The more "Yes" answers you have, the greater your chance of having a fall. **Be aware of what can cause falls, and take care of yourself to stay independent and falls-free!**

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Pain

- Pain can affect everyday life
- Best practice for asking about pain at every face to face regardless of condition
  - If they say yes, get more information
- Three pain scales available
  - 0-10 Numeric Rating Scale (ages 9 year and older)
  - Wong-Baker Faces Pain Rating Scale (ages 3 and older)
  - FLACC Behavioral Pain Assessment Scale (face, legs, activity, cry and consolability. If self-report is not possible. Ages 2 months to 7 years and if individuals any age not able to communicate their pain)

234

PHQ-9 and GAD-7

Anxiety and depression are the most common mental disorders and often appear together. Screening tools often used include:

- The PHQ-9 which can identify potential depression
- GAD-7 which can help identify potential anxiety
- Both tools are most reliable when self-administered
- A positive screening for either or both should lead to a referral to a behavioral health provider or PCP depending on client preference

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PHQ-9 and GAD-7 Screening Tips

- Normalize the screening; don't make it a big deal
- Some people respond better to terms like "stress" when talking about their anxiety or "sadness" rather than depression
- Everyone experiences sadness and this tool might help identify how it might be impacting you
- Remember the power that stigma holds - many people do not want to self-identify
- Treatment can be very effective

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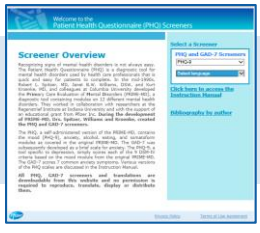
Translations of PHQ-9 and GAD-7

The website sponsored by Pfizer is located at:

http://www.phqscreeners.com/select-screener



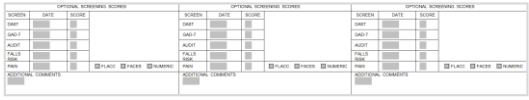
237

HAP Form Instructions (cont.)

Enter the date the screening was completed

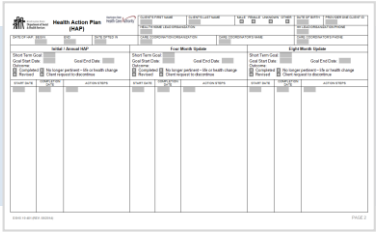
Enter the score

Screening may be completed at any time during each four month activity period or more often as clinically indicated



238

HAP: Pages 2 Through 7



239

Short Term Goals

- Enter the short term goal
- Enter the short term goal begin date
- When a goal ends enter the date and check the reason the goal ended
- Enter the action steps, specifying who will complete the step and the start date
- Goals that are not completed may be carried over to the next four month activity period
- Goals may be revised at any time to reflect changes with the client

240

The Health Action Plan (HAP)

Develop goals and action steps that are **SMART**:

Specific
Measurable
Achievable
Relevant
Time-limited

241

Health Action Plan – First Short Term Goal

Long Term Goal
Participate in church activities with my family.

Short Term Goal # 1
Debbie would like to improve stamina and gain strength
and be able to remain out of her bed for four hours or more each day.

Action Steps

1. Debbie and Care Coordinator will brainstorm common events in Debbie's life that promote activity as well as those that promote inactivity.
2. Debbie will maintain activity log for two weeks and review with Care Coordinator during next visit on 10/7/2020.

242

Health Action Plan – Second Short Term Goal

Long Term Goal
Participate in church activities with my family.

Short Term Goal # 2
Debbie would like to decrease use of pain medication.

Action Steps

1. Debbie will document use of pain medications, her activity, and functional ability daily starting 12/1/2020 using the pain log provided by the Care Coordinator.
2. Debbie will make an appointment with PCP to discuss chronic pain management options by 12/20/2020.
3. Care Coordinator will review the pain log and inquire about Debbie's appointment with her PCP during the home visit schedule on 12/28/2020.

243

Let's Pause to Check for Understanding

What experiences have you had offering, administering and providing follow-up to these screenings in the past?

Do you have any questions?

244

Small Group Work

Considering your client's PRISM results, PAM responses and Level of Activation:

- Fill out the HAP form (make up scores as needed for this activity)
- Write the following on the flip chart:
  - **One long-term goal**
  - **One short-term goal**
  - **Actions steps to reach the short-term goal**
    - **Who will complete the step and by when?**
  - **Which of the 6 Health Home services might the client need now and in the near future?**
  - **Which optional screenings might be helpful for your client?**

245

Maintaining Behavioral Change

Sustaining the gains with healthy strategies

Maintaining behavioral change takes time (usually 6 months to two years)

Monitoring using relapse prevention and resiliency planning

Progressing by realizing that relapse is one step forward on the client's journey

Pursuing new goals and activities

246

Final Notes About the HAP

- Provide the HAP information to the client, or with the client's consent, to the caregiver and family
- The HAP may be:
  - Printed and mailed
  - Delivered at the face-to-face visit
  - E-mailed using secure mail and/or encryption
- Each face-to-face visit or telephone contact provides an opportunity to discuss and review progress on the HAP
- The HAP is a fluid document that changes with the client's needs and preferences

247

Let's Pause to Check for Understanding

How can you work with your client to increase the value of the HAP?

Do you have any questions about the HAP?

248

Care Transitions

"Health Care Without Complications"

All materials in this section are adopted from the "Reducing Readmissions: Care Transitions Toolkit" from the WASHINGTON STATE HOSPITAL ASSOCIATION.

To download a copy of the toolkit go to

http://www.wsha.org/wp-content/uploads/WSHACareTransToolkit.pdf

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TRAINING

Hospital Readmissions

Research shows that 20% of patients in the U.S. are re-hospitalized within 30 days of discharge.

Addressing social and resource barriers early in the admission not only prevents unnecessary readmissions, but also proactively prevents delayed discharges and unnecessary increases in the length of stay

250

What Causes Readmissions?

- Unresolved social or resource issues:
  - Medical issues are not always the reason
- Lack of strategies that incorporate both social and medical factors resulting in poorly executed transitions and poor outcomes for the client which impact:
  - Family and support systems
  - Caregivers: paid and unpaid
  - Client's health and stability

251

Washington State Care Transitions

Washington State "Care Transitions" is a state-wide initiative to foster safe, timely, effective, and coordinated care as clients move between settings

Care Coordination includes collaborating on the discharge Plan of Care with the primary care physician (PCP) and multidisciplinary care team

252

How Will You Know if a Client Has Been Hospitalized?

Review PRISM data: there is a lag in submission of billing claims

Emergency Department Information Exchange (EDIE): find out if your Lead or agency subscribe to this service

Some Leads use PreManage, a system that notifies them of emergency department visits and hospital admissions and discharges

Find out who at your agency receives these alerts

253

Six Strategies for Care Transitions

1. Consistent plan of care with the PCP and home health care (if applicable) upon arrival and discharge from the hospital
2. Coordinated follow up call or visit at discharge
3. Timely visit to PCP
4. Reconciliation of medications soon after transition
5. Client, family, and caregiver education coordinated between settings
6. Support through increased care management for high-risk clients

254

Social/Resource Barriers Assessment

Evaluate, **assess,** and **complete** a needs assessment of client's home-going needs and barriers to care including support requirements.

The Katz ADL may be used as a tool for assessing the client's abilities and care needs.

255

Social and Resource Barriers

- Personal care needs
- Other disabilities
- Limited income
- Financial reserves
- Unstable or unsafe housing
- Inaccessible housing
- Coping skills
- Employment
- Health literacy or numeracy
- Lack of an advance directive
- Religious or spiritual support
- Education
- Substance use history
- Psychiatric history
- Availability of mental health or SUD services
- Demands on other family members or caregivers
- Transportation

256

Client, Family, and Caregiver Follow-up

- What are the discharge orders?
- Do they have a copy of the discharge orders and do they understand them?
- What warning signs or symptoms should be reported to the healthcare provider? Do they have the phone number to the 24 hour nurse line?
- What follow-up is necessary?
- Have the follow-up appointments been scheduled?
- Is the client aware of these appointments and do they need transportation and/or an escort to the appointment/s?
- What are the current medications?

257

Does the Client or Caregiver Know Which Red Flags May Require a Call to the Provider?

- Chest pain or palpitations
- Cough
- Infection
- Blurred vision, loss of vision
- Headache
- Fatigue
- Insomnia or problems sleeping
- Discharge
- Warmth to an affected area
- Fever
- Pain
- Nausea and/or vomiting
- Poor appetite
- Weight loss or weight gain
- Bleeding
- Constipation or diarrhea
- Difficulty urinating or no urination
- Dizziness
- Falls

258

Triage Grid for Follow Up With PCP

Communication and Follow-Up Based on Patient Triage/Clinical Need				
Patient	Criteria	Appointment Needed w/in	Provider Handoff	Plan of Care Transfer
High Risk	• Admitted 2 or more times in the past year • Unable to teach back • Low likelihood to follow treatment plan • High likelihood patient readmitted within 30 days	48 Hours	Doctor to Doctor	Phone and FAX
Moderate Risk	• Admitted once in the past year • Moderate likelihood to follow treatment plan • Moderate likelihood patient readmitted within 30 days	5 – 7 days	Hospital to PCP Team	EHR or FAX
Low Risk	• No other admission in the past year • Able to teach back • Low likelihood patient readmitted within 30 days	As Needed	Hospital to PCP Team	EHR or FAX

Clients who are at very high risk need a quicker and stronger communication process between providers while those at lower risk do not need as intensive of care.

Created by WA physicians and hospitals with evidence from the Institute for Healthcare Improvement

259

Medication Reconciliation Defined

Medication reconciliation is:

A **process of comparing** the medications a client took prior to admission to a hospital, nursing facility, or other in-patient center with those ordered by the physician at the time of discharge.

Should also be completed when the client visits their PCP to ensure that the medication record is **accurate and up to date**.

Reduces the potential for administering the wrong dosage, administering a discontinued medication, taking the same medication more than once (e.g. taking the name brand and the generic of the same medication), and/or using expired medications.

260

Medication Reconciliation

- During the hospital stay: anticipate needs
- Care Coordinator will provide or ensure that it is completed by a qualified professional

Note: clients who discharge from a facility against medical advice (AMA) may not receive their prescribed medications when they exit the facility. The need to follow up on medication orders and to fill prescriptions becomes even more critical.

261

Medication Reconciliation (cont.)

Who can help reconcile medications?

- Primary care physicians (PCP)
  - The PCP's nurse or physician's assistant (PA)
- Family members
- Pharmacists
- Pharmacies that deliver bubble-packed medications to adult family homes
- Home Health nurses
- Adult Day Health Centers
- Nurses in nursing facilities, assisted living, adult family homes, and other institutions

262

Follow-up Scripts from "Reducing Readmissions: Care Transitions Toolkit"

263

TRAINING

"Teach Back"

Literature shows "Teach Back" is one of the most effective methods for educating clients. Teach Back involves asking the patient, family, or caregiver to recall and restate in their own words what they thought they heard during education or other instructions.

Be aware of the client or caregiver activation level when teaching or using "teach back" techniques.

An example of teach back is to ask your client if they can show you how to locate the number for the 24 –hour nurse helpline

264

TRAINING

Let's Consider Our Vignettes

- If Carmella was hospitalized what transition services might you provide?
- How would you work with Sacha if she admits to the hospital and then to the nursing facility and is returning home?

NOTE: when entering a hospital, nursing facility, or other institution introduce yourself to staff each time you enter the facility so staff is aware of your role and services you may offer.

265

What Were the Six Strategies for Care Transitions?

1. Consistent plan of care with the PCP and home health care (if applicable) upon discharge
2. Coordinated follow up call or visit at discharge
3. Timely visit to PCP
4. Reconciliation of medications soon after discharge
5. Client, family, and caregiver education coordinated between settings
6. Support through increased care management for high-risk clients

266

Let's Pause to Check for Understanding

What experience have you had professionally or personally with effective discharge from a hospital or other inpatient setting?

Do you have any questions about Care Transitions?

267

Documentation, Quality Assurance, and Time Management

268

Documentation Guidelines

- These are general guidelines
  - Suggested practices
- Ask your Lead/s for their guidelines
  - Data platforms will vary
  - Ask for their client file checklist
- Consult your supervisor
  - What are your agency's requirements?
  - What are best practices?
- Professional standards for your credential and experience
- Documentation should be completed timely

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TRAINING

General Format for Documentation

- Name and title of writer
- Date
- Type of contact
- Who contact was with (if language barrier, was there an interpreter?)
- Core service provided
- Highlights from the conversation
- Objective observations
- Other relevant comments
- Plan for next steps or conclusion
  - Specify due dates and who is responsible
  - If a plan or action is to be completed, was it documented that follow-up occurred in the next note?

270

General Tips for Documentation

- Notes are part of the client record – be professional
- Be objective
- Use spell check
- Do not use all CAPS
- If quoting a client use quotation marks
- Do not use acronyms, abbreviations or shorthand unless defined in each note
- Remember - If it is not documented, it didn't happen

271

Something to Consider

- If another staff read your narrative would they understand the acronyms, abbreviations or shorthand you use?
- If someone assumed your case could they find a case history?
- Would they know where to pick up after the previous Care Coordinator or allied staff?
  - What referrals need to be completed or need to be managed?
  - What follow-up needs to be completed? Has follow-up been documented?
  - What actions steps are the client, Care Coordinator, or others doing and by when?

272

Documentation Example

FTF w/ Sacha at her home. First time meeting b/c her regular CC is on medical leave. She is 69 y.o. woman living alone and has a CG 4 hpd. She has diabetes and other dx including possible MI. Is a PAM level 4 which doesn't seem right b/c in the last yr she's been to ED 30 x's and hosp. 4 x's w/ most recent in a diabetic coma. Discussed how she needs to follow PCPs orders and tx plan or she could end up in hosp. again w/ serious complications. Sacha nodded and said she understands and will try harder. Plan to f/u next mo. to see if she is following orders.
HH Svc = Comprehensive Care Management, Health Promotion & Comprehensive Transitional Care Tier = 2

273

Quality Assurance

- Leads complete their audits for client records
  - Ask for their case file checklist
- Health Care Authority (in partnership with DSHS)
  - Audits 10-15 dient files each year
  - Proficiency rate is usually 90%
    - Nine out of ten records reviewed meet the requirement
- Leads often use the results of their internal audits and findings from HCA to develop training
  - Ask your Lead for technical assistance

274

What Are Reviewers Looking for in a Client File?

Note: requirements change with each update of the Lead's contract/s. QA elements and focus may change.

275

Core Services

- Does the case narrative indicate which of the six Health Home core service/s was provided during the month?
  - Indicate services provided by allied staff under the supervision or coordination of the Care Coordinator
    - If allowed, allied staff should document their activities in the case narrative

276

Completion of Forms

- Was the Participation Authorization and Information Sharing Consent Form completed, signed, and dated?
  - If not is there a note in the case narrative citing the reason the form was not completed and signed by the client, parent, or guardian?
  - Were additions and deletions dated and initialed by the client, parent, or client representative (POA, guardian)?
- Was the Opt-Out Form completed, signed, and dated?
  - If the client does not complete the form is there a narrative documenting the client's verbal request to opt-out?
  - Was a copy of the completed form mailed to the client (whether completed by the client or the Care Coordinator)

277

Required and Additional Screenings

- Required Screenings – PAM®, CAM®, or PPAM®, BMI, Katz ADL, PHQ-9 or PSC-17
  - Document the date required screenings were completed and the score (and level for the Patient Activation Measures ®)
  - If the client, parent, or guardian decline to complete a screening document the date it was offered. Also include the reason if known
    - For example, a parent declined the PPAM ® because the child was ill and needed the parent's care
- Additional screenings – DAST, GAD-7, AUDIT, Falls Risk, Pain
  - Required when applicable to the client's health needs
    - If the client, parent, or guardian decline to complete additional screening document the date it was offered and the reason if known
- Document follow-up to referrals or other actions

278

HAP

- Were all fields completed?
  - If not, is there an explanation?
- Were person-centered short and long term goals created?
  - Action steps to achieve the client's prioritized short term goal and who is responsible to complete each step
- Was HAP information shared with the client, parent, family member, or guardian?
  - Formats vary depending on the Lead

279

Key Considerations to Document

- In-person visit with the client to develop and finalize the HAP
- Completion of the HAP within 90 days of enrollment with the Care Coordination Organization
- Case narrative supports the Tier that was billed
- Monthly in-person and telephonic interactions with the client
- Completion and update of the HAP (including screenings) at least once during every activity period or when there was change in the client's health status, needs, or preferences

280

Key Considerations to Document (cont.)

- Provision of services in a culturally competent manner with equal access for clients with language and communication barriers
- Services are delivered
  - In the client's primary language (document if interpreter used)
  - Recognizing cultural differences and obstacles faced by persons with a developmental disability
  - Recognizing the dynamics of substance use
- Provision of services tailored to special needs such as functional impairment or environmental factors

281

Key Considerations to Document (cont.)

- Communication and coordination between the client and the client's service providers and other support systems to address barriers and achieve health action goals
- Provision of individual and family support through care coordination and care transition activities
- Development and/or coordination of multidisciplinary teams to provide assistance as needed

282

Key Considerations to Document (cont.)

- Provision of educational materials that:
  - promote improved clinical outcomes
  - increase self-management skills
  - are appropriate to the level of activation

  Note: Document any educational information sent out in client's preferred language if other than English
- Use of peer supports to increase the client's knowledge about their health conditions and adherence to treatment

283

Key Considerations to Document (cont.)

- Discussion about advance care planning with the client, parent, or collateral
  - Within the first year that the client agrees to participate in the Health Home Program
  - If this was not completed by a previous Care Coordinator then document that a discussion was offered to the client, parent, family member, or guardian
- Assistance provided to maintain the client's eligibility for programs and services as needed
- Referrals to available community resources to help achieve health action goals

284

Key Considerations to Document (cont.)

- Process for notification of the client's admission or discharge from an emergency department or an inpatient setting
  - Because we do not duplicate benefits, if another agency, such as the MCO, is providing care transitions, note this is the case narrative
- Provision of care transition to prevent avoidable readmissions after discharge from an inpatient facility and ensure proper and timely follow-up care
- Participation by the Care Coordinator in all *appropriate* phases of care transition

285

Potential Monitoring Questions

- **Encounter Data:** Evidence that the submitted encounter data matched the service level provided
- **Consent:** Evidence of a completed (updated when applicable) and signed "Health Home Information Sharing Consent Form"
- **Timely Interactions:** Evidence of periodic in-person and telephonic interactions with enrollees
- **Initial HAP:** Evidence that the date of service on the G9148 encounter submission was within 90 days of enrollment of the review period, as required

286

Potential Monitoring Questions

- **Health Action Plan:** Evidence the HAP was completed and updated every activity period (or more frequently when there was a change in the enrollee's health status, needs, or preferences)
- **Goals:** Evidence within the HAP of the enrollee's person-centered short-term and long-term health action goals
- **Action Steps:** Evidence within the HAP of goal-related action steps and identification of who was responsible to complete each step

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Potential Monitoring Questions

- **Activation Measure:** Evidence within the HAP of documented, completed and scored activation measures, including: Patient Activation Measure/PAM®; Caregiver Activation Measure/CAM®; and Parent Patient Activation Measure/PPAM®
  - Note: If the enrollee declined screening, the HAP must document the date and reason the enrollee declined
- **Required Screenings:** Evidence within the HAP of required screenings, including: BMI; KATZ-ADL; PHQ 9 or PSC 17 scores
  - Note: If the enrollee declined screening/assessment, the HAP must document the reason and date the enrollee declined

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Potential Monitoring Questions

- **Additional Screenings:** Evidence of the use of additional screenings (e.g., GAD7, Falls risk, pain level) when applicable
  - Note: If the enrollee declined screening/assessment, the HAP must document the reason and date the enrollee declined
- **HAP Provided:** Evidence the Care Coordinator provided HAP information to the enrollee, or to the enrollee's caregiver and family with the enrollee's consent

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Potential Monitoring Questions

- **Communication:** Evidence the Care Coordinator facilitated communication and coordination between the enrollee and their providers and other support systems, in an effort to address identified barriers and achieve health action goals
  - (Other support systems may include, but are not limited to family, caregivers, primary care providers, mental health treatment providers, and authorizers of long term services and supports and/or chemical dependency treatment providers)

290

Potential Monitoring Questions

- **Multidisciplinary Team:** Evidence the Care Coordinator developed and coordinated multidisciplinary teams to review and provide assistance with the enrollee's case when applicable
- **Health Promotion Materials:** Evidence the Care Coordinator provided or provided access to educational materials, based on the enrollee's level of activation and chronic conditions, including, but not limited to: Customized educational materials; Wellness and prevention education specific to the enrollee's chronic conditions; Mentoring and modeling communication with providers; and Links to resources

291

Potential Monitoring Questions

- **Person-Centered Care Coordination:** Evidence demonstrating person-centered care coordination occurred with interventions tailored for the medical, social, economic, behavioral health, functional impairment, cultural and environmental factors that affect the enrollee's health and health care choices by:
  - Recognizing cultural differences when developing the HAP
  - Understanding the dynamics of substance use disorder without judgement
  - Recognizing obstacles faced by persons with developmental disabilities
  - Providing assistance to the enrollee and his or her caregivers in addressing the obstacles
  - Treating enrollees with respect or dignity

292

Potential Monitoring Questions

- **Transitional Care:** Evidence of comprehensive transitional care addressing the enrollee's specific health needs to prevent avoidable readmission after discharge from an inpatient facility to include proper and timely follow-up care
- **Notification System:** Evidence of a prompt notification process of the enrollee's admission or discharge from an emergency department or an inpatient setting including the documentation of follow up care

293

Potential Monitoring Questions

- **Advance Care Planning:** Evidence that the CC documented discussion regarding advance care planning with the enrollee
- **Individual and Family Support:** Evidence the CC provided individual and family support when providing care coordination, care management, and transitional care activities when applicable
- **Community Resources:** Evidence of identification and referral to available community resources to help achieve health action goals
  - i.e.: Long-term services and supports; Mental health services; Substance use disorder services; Legal services; and Food banks

294

Potential Monitoring Questions

- **Assistance with Eligibility:** Evidence the Care Coordinator assisted the enrollee in obtaining and maintaining eligibility as needed for services
  - i.e.: Health care services; Disability benefits; Housing; Personal needs; and Legal services
- **Cultural Competency:** Evidence the Care Coordinator provided services with cultural humility that addresses health disparities through direct interaction with the enrollee in his or her primary language

295

Potential Monitoring Questions

- **Screening Follow-up:**
  - Evidence in the file for referrals to providers (PCP or behavioral health provider) when the PHQ-9 score is above 10
  - Evidence in the file the CC used the PAM®, CAM®, or PPAM® to target tools and resources commensurate with the enrollee's level of activation

296

Time Management

- Plan your day/week by scheduling time for:
  - Outreach calls and letters
  - Face-to-face visits
  - Follow-up calls
  - Making and actively managing referrals
  - Working with allied staff and multidisciplinary care teams
  - Documentation
- Schedule time for responding to EDIE or PreManage alerts
  - Carve out time in your schedule and if no one has been hospitalized or admitted in the ED use this time for the above activities

297

Let's Pause to Check for Understanding

What tips can you share that have helped you better manage your caseload?

Do you have any questions?

298

First Meeting, Safety and Incident Reporting

299

First visit

- The first visit is a lot about making connections and giving the client time to tell you what they need. Try not to inundate them too much with information
- Create a folder to take with you that includes everything you will need for the client

300

What to bring to the first visit

- Client phone number and current address, directions or specific instructions on parking
- HH Participation authorization and information sharing consent form
- ROI for SUD
- HH Adolescent Information Sharing Consent (if necessary)
- PAM/PPAM/CAM
- KATZ
- PHQ-9/PSC-17
- BMI chart
- All optional assessments (Pain, Falls, DAST, AUDIT, and GAD-7)
- Advanced care planning literature (may hold off for future visit)

301

What to bring to the first visit

- Paper HAP
- Goal Setting and Action Planning Worksheet
- Crisis number and non-emergency police number
- Other numbers for common resources/referrals
- List of numbers for local community resources (food bank, DME lending programs, etc.)
- List of DSHS workers (APS, case manager, financial workers)
- Agency or MCO specific resources
- HH brochure
- Business card
- Paper and pen and/or laptop
- Cell phone to make any necessary calls for client

302

Safety

Tips for Safety Before a Home Visit

- While scheduling the visit ask the client about their home environment:
  - Are there pets, will they be on a leash or in a fenced yard?
  - Do others live with the client or will others attend the visit, what is their relationship?
  - Ask about the neighborhood, get directions, and ask if there are any special instructions for access to the home or parking
- Check out the location to determine if it is in a potentially dangerous area
- Schedule appointments when travel may be easier (e.g. avoid rush hour or inclement road conditions when temperatures drop)

303

Safety

Tips for Safety Before Leaving the Office

- Ensure that your cell phone is fully charged
- Make certain that your vehicle has plenty of gas to ensure that you are not stranded in isolated areas
- Avoid carrying a purse and valuables. Dress conservatively wearing shoes that will enable you to move quickly
- Leave your itinerary with the client's name and contact information with a coworker or supervisor. Consider partnering with a coworker and call when you are safely in your vehicle to report that your departure from the visit

304

Safety

When You Arrive at the Home

- Park your vehicle so that it cannot be blocked in a driveway, facing the direction you will leave. Consider parking the vehicle so it is out of sight of the home
- Consider calling the client from your vehicle to let them know that you have arrived
- Be aware of hazards or other safety concerns such as broken porch steps, unrestrained pets or yelling and other aggressive actions
- Choose a location to sit that allows you access to an exit
- Trust your intuition, remain calm, and do not complete the visit if you feel unsafe. Safety first!

305

Incident Reporting


Health Home Incident Report

306

TRAINING

Resources

307

Non-emergency Medical Transportation (NEMT) Program

- Transportation may be provided to Health Home clients for services when the client is homeless or lives in an unhealthy or unsafe environment
- A Care Coordinator may request NEMT to alternate locations to conduct care coordination services such as:
  - obtaining consent to participate
  - administering health assessments
  - developing the HAP

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TRAINING

Interpreter Services

- For information refer to document in the Classroom Training Manual
  - Ask your manager or accountant for your agency's National Provider Identification (NPI) number so that you can schedule interpreters
    - Your agency may have more than one NPI number so ask which number you should use for your Health Home clients

Overview of HCA Interpreter Services Program

Frequently Asked Questions

309

TRAINING

Working with Providers

Offer this letter when visiting your client at nursing facilities, hospitals, and other residential providers (assisted living facilities and adult family homes)

Health Home Program
Washington

Dear Administrator or Staff,

I am a Health Home Care Coordinator with: _____

I am here because one of your residents is eligible for the Health Home Program. The program is voluntary and is provided at no cost to eligible Medicaid and Medicaid/Medicare clients. The state identified one or more of your residents who are eligible to receive my services.

The Health Home Program helps residents who have one or more chronic diseases. These residents are at risk for other health problems and higher medical costs.

Care Coordinators help your resident(s) create a Health Action Plan, which includes personalized health goals. I can assist you by providing Health Home activities such as:

1. Teaching your resident about their health
2. Coaching family members to support your resident and you
3. Referring your resident to services outside of routine care
4. Helping you with care transitions when your resident returns from a hospital or nursing facility

Your resident may receive monthly visits and phone calls as part of their Health Home services. I look forward to working with you to support your resident in reaching their health goals.

Health Care Authority

Name of Client	ID#

Best Practices When Visiting Facilities

- Follow facility sign in/out procedure
- Attempt to adhere to reasonable visiting hours
- Understand basic workings of facilities and roles of staff
- Prearrange visits and private space for meetings
- Provide Residential Introduction Letter
- Have organization identification
- Attain contact information of staff
- Knock and wait for response before entering client's room
- Communicate with HCS case manager (if applicable)

Community Living Connections (CLC)

Easy to navigate:

- Website is located at: https://washingtoncommunitylivingconnections.org/consumer/
- Enter zip for client's location and select type of service

DSHS Health Home Website Quick Links: Care Coordinators Links

- Contains Guide Sheets
  - Advance Care Planning
  - Depression Screening and Intervention
- Training schedules and invitations to monthly webinars
- Educational materials for health promotion
- Classroom Training Manual and PowerPoint Handout
- Health Home Herald issues


Health Home Herald 2021

Engaging Clients with Limited Decision-Making Capacity

313

Advance Care Planning


Health Home Program Washington

CARE COORDINATOR ADVANCE CARE PLANNING (ACP) GUIDE SHEET

OVERVIEW

Determining our preferences for health care, medical emergencies, disability, and end of life care poses a challenge not only for ourselves but also for our clients, parents, caregivers, and family members.

Advance Care Planning (ACP) is a process in which an individual explores their goals, values, and beliefs and considers what health care they would want in their future, including wishes and preferences for care at the end of life. It involves choosing a health care agent who can communicate their wishes if they can no longer speak for themselves, and having conversations with their loved ones about their choices.

An Advance Directive (AD) is a legal document that includes two parts: a health care directive for documenting client treatment wishes and a durable power of attorney for health care used to name their selected health care agent (HCA).

YOUR ROLE AS A CARE COORDINATOR

One service Care Coordinators (CCs) are required to provide is the opportunity for clients to consider and discuss ACP. While CCs do not draft ADs for their clients they should assist clients and their families in accessing legal assistance if they wish to complete an AD. A discussion about ACP must be offered within the first year of the client's agreement to participate in the Health Home program. CCs are expected to simply begin the conversation to determine the client's interest in ACP. This offer of assistance and any actions taken should be documented in the client's case record.

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TRAINING

Developing Relationships and Resources

Lead Organizations have completed outreach activities with local hospitals and institutions

Care Coordination Organizations are encouraged to complete their own outreach to community partners and medical and behavioral health providers to establish working relationships to aid in their care coordination activities

Communicate with case managers and staff at HCS, DDA, AAAs, and other agencies about the program and your role

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Let's Pause to Check for Understanding

Do you have any questions?

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Additional Training

Required Special-topic Training
Optional Training

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Required Training for Fee-for-Service and MCO Health Home Program

Special topic learning modules are located at the DSHS Health Home website:
https://www.dshs.wa.gov/altsa/home-and-community-services/washington-health-home-program-going-training

The mandated topics are:

1. Outreach and Engagement Strategies
2. Navigating the LTSS System
3. Cultural and Disability Competence Considerations
4. Assessment Screening Tools
5. Coaching and Engaging Clients with Mental Health Needs
6. Medicare Grievance and Appeals (required if working for Duals)

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Register and Join for Our Monthly Webinars

Ask your Lead for the link to register for each quarterly series or visit the DSHS Care Coordinators website for invitations https://www.dshs.wa.gov/altsa/washington-health-home-program-%E2%80%93-training-invitations

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DSHS Website is Located At:

https://www.dshs.wa.gov/altsa/washington-health-home-program

Resources for Care Coordinators and Allied Staff

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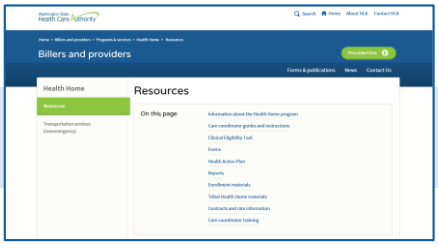
HCA Website is Located At:

https://www.hca.wa.gov/billers-providers/programs-and-services/health-homes



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Let's Pause to Check for Understanding

Do you have any final questions?

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Review of the Learning Objectives

What are the six core Health Home Services?

Describe outreach and engagement strategies you will use.

Describe the key uses of PRISM in care coordination.

How could you use the results of the patient, parent, or caregiver activation measures in working with your client or their collaterals?

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Review of the Learning Objectives (cont.)

What are the required and optional screens used in the HAP?

How does the HAP support the client to improve their health and self-management?

What are the crucial activities of comprehensive transitional care?

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Please Complete the Training Evaluation

We appreciate your feedback!

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TRAINING